

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8416 CERTIFICATE OF DEATH

Reg. Dist. No. 302

08393

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 19 Mos				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Washington Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 120 So Prospect St				d. STREET ADDRESS 120 So Prospect St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE BERNARD ALEXANDER First Middle Last				4. DATE OF DEATH July 11 1959 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 17 1876 9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt Natl Parks		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles W. Alexander				14. MOTHER'S MAIDEN NAME Carrie Sheehan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Spanish American (Type of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Laura Alexander 120 So Prospect St Hagerstown Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Generalized arteriosclerosis & malnutrition DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH See above	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/9/54 , 19____, to 7/11/59 , 19____, that I last saw the deceased alive on 7/10/59 , 19____, and that death occurred at 4A M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 N. Potomac St. Hagerstown, Maryland DATE SIGNED 7/11/59							
ACTUAL SIGNATURE Howard N. Weeks				PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/14/59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md. ADDRESS				24a. REC'D BY REGISTRAR Jul 14 '59		24b. REGISTRAR'S SIGNATURE William S. Kline	

CERTIFICATE OF DEATH

1915

THE OUT-OF-TOWN

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1870		New York		New York		Heart Disease		Jan 15, 1915		10:00 AM		New York		J. Doe, M.D.		J. Doe, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Jane Smith		Female		30		Mar 10, 1885		Maryland		Maryland		Pneumonia		Mar 20, 1915		5:00 PM		Maryland		J. Smith, M.D.		J. Smith, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Robert Johnson		Male		60		Sep 5, 1855		Maryland		Maryland		Stroke		Sep 10, 1915		12:00 PM		Maryland		J. Johnson, M.D.		J. Johnson, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Mary White		Female		25		Jul 15, 1890		Maryland		Maryland		Tuberculosis		Jul 25, 1915		8:00 PM		Maryland		J. White, M.D.		J. White, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
William Brown		Male		55		Apr 20, 1860		Maryland		Maryland		Heart Failure		Apr 30, 1915		11:00 AM		Maryland		J. Brown, M.D.		J. Brown, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Elizabeth Green		Female		40		Oct 1, 1875		Maryland		Maryland		Cancer		Oct 15, 1915		3:00 PM		Maryland		J. Green, M.D.		J. Green, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Thomas Black		Male		70		Dec 10, 1845		Maryland		Maryland		Old Age		Dec 20, 1915		9:00 AM		Maryland		J. Black, M.D.		J. Black, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Margaret Lee		Female		35		Jun 5, 1880		Maryland		Maryland		Pneumonia		Jun 15, 1915		7:00 PM		Maryland		J. Lee, M.D.		J. Lee, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Charles Hall		Male		65		Mar 1, 1850		Maryland		Maryland		Heart Disease		Mar 10, 1915		10:00 AM		Maryland		J. Hall, M.D.		J. Hall, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Anna King		Female		20		Aug 10, 1895		Maryland		Maryland		Tuberculosis		Aug 20, 1915		6:00 PM		Maryland		J. King, M.D.		J. King, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
George Miller		Male		50		Nov 1, 1865		Maryland		Maryland		Stroke		Nov 10, 1915		11:00 AM		Maryland		J. Miller, M.D.		J. Miller, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Helen Wilson		Female		30		Feb 15, 1885		Maryland		Maryland		Pneumonia		Feb 25, 1915		8:00 PM		Maryland		J. Wilson, M.D.		J. Wilson, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Frank Davis		Male		40		May 1, 1875		Maryland		Maryland		Heart Failure		May 10, 1915		12:00 PM		Maryland		J. Davis, M.D.		J. Davis, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Alice Taylor		Female		25		Sep 10, 1890		Maryland		Maryland		Tuberculosis		Sep 20, 1915		7:00 PM		Maryland		J. Taylor, M.D.		J. Taylor, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Edward Scott		Male		60		Dec 1, 1855		Maryland		Maryland		Stroke		Dec 10, 1915		10:00 AM		Maryland		J. Scott, M.D.		J. Scott, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Bertha Adams		Female		35		Jul 5, 1880		Maryland		Maryland		Pneumonia		Jul 15, 1915		6:00 PM		Maryland		J. Adams, M.D.		J. Adams, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Harold Baker		Male		55		Apr 20, 1860		Maryland		Maryland		Heart Disease		Apr 30, 1915		11:00 AM		Maryland		J. Baker, M.D.		J. Baker, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Lillian Clark		Female		20		Aug 10, 1895		Maryland		Maryland		Tuberculosis		Aug 20, 1915		8:00 PM		Maryland		J. Clark, M.D.		J. Clark, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Clarence Evans		Male		45		Mar 1, 1870		Maryland		Maryland		Stroke		Mar 10, 1915		12:00 PM		Maryland		J. Evans, M.D.		J. Evans, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Dorothy Foster		Female		30		Jun 15, 1885		Maryland		Maryland		Pneumonia		Jun 25, 1915		7:00 PM		Maryland		J. Foster, M.D.		J. Foster, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Walter Gibson		Male		65		Nov 1, 1850		Maryland		Maryland		Heart Failure		Nov 10, 1915		10:00 AM		Maryland		J. Gibson, M.D.		J. Gibson, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Beatrice Harris		Female		25		Sep 10, 1890		Maryland		Maryland		Tuberculosis		Sep 20, 1915		6:00 PM		Maryland		J. Harris, M.D.		J. Harris, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Norman Jones		Male		50		Apr 20, 1865		Maryland		Maryland		Stroke		Apr 30, 1915		11:00 AM		Maryland		J. Jones, M.D.		J. Jones, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Evelyn King		Female		30		Feb 15, 1885		Maryland		Maryland		Pneumonia		Feb 25, 1915		8:00 PM		Maryland		J. King, M.D.		J. King, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Frederick Lee		Male		40		May 1, 1875		Maryland		Maryland		Heart Failure		May 10, 1915		12:00 PM		Maryland		J. Lee, M.D.		J. Lee, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Gladys Miller		Female		25		Aug 10, 1890		Maryland		Maryland		Tuberculosis		Aug 20, 1915		7:00 PM		Maryland		J. Miller, M.D.		J. Miller, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Herbert Wilson		Male		60		Dec 1, 1855		Maryland		Maryland		Stroke		Dec 10, 1915		10:00 AM		Maryland		J. Wilson, M.D.		J. Wilson, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Irene Adams		Female		35		Jul 5, 1880		Maryland		Maryland		Pneumonia		Jul 15, 1915		6:00 PM		Maryland		J. Adams, M.D.		J. Adams, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Jesse Baker		Male		55		Apr 20, 1860		Maryland		Maryland		Heart Disease		Apr 30, 1915		11:00 AM		Maryland		J. Baker, M.D.		J. Baker, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Katherine Clark		Female		20		Aug 10, 1895		Maryland		Maryland		Tuberculosis		Aug 20, 1915		8:00 PM		Maryland		J. Clark, M.D.		J. Clark, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Lester Evans		Male		45		Mar 1, 1870		Maryland		Maryland		Stroke		Mar 10, 1915		12:00 PM		Maryland		J. Evans, M.D.		J. Evans, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Mildred Foster		Female		30		Jun 15, 1885		Maryland		Maryland		Pneumonia		Jun 25, 1915		7:00 PM		Maryland		J. Foster, M.D.		J. Foster, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Nathan Gibson		Male		65		Nov 1, 1850		Maryland		Maryland		Heart Failure		Nov 10, 1915		10:00 AM		Maryland		J. Gibson, M.D.		J. Gibson, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Olive Harris		Female		25		Sep 10, 1890		Maryland		Maryland		Tuberculosis		Sep 20, 1915		6:00 PM		Maryland		J. Harris, M.D.		J. Harris, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Philip Jones		Male		50		Apr 20, 1865		Maryland		Maryland		Stroke		Apr 30, 1915		11:00 AM		Maryland		J. Jones, M.D.		J. Jones, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Rebecca King		Female		30		Feb 15, 1885		Maryland		Maryland		Pneumonia		Feb 25, 1915		8:00 PM		Maryland		J. King, M.D.		J. King, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Samuel Lee		Male		40		May 1, 1875		Maryland		Maryland		Heart Failure		May 10, 1915		12:00 PM		Maryland		J. Lee, M.D.		J. Lee, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Theresa Miller		Female		25		Aug 10, 1890		Maryland		Maryland		Tuberculosis		Aug 20, 1915		7:00 PM		Maryland		J. Miller, M.D.		J. Miller, M.D.	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Victor Wilson		Male		60		Dec 1, 1855		Maryland		Maryland		Stroke											

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08394

FOR STATE
HEALTH DEPT.

8417

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 428 W. Franklin St.	
c. LENGTH OF STAY IN 1b 9 yrs.		d. STREET ADDRESS Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 428 W. Franklin St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LARRY Middle WAIN Last ANDREWS		4. DATE OF DEATH Month July Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1935
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months 23 Days 23 Hours 23 Min.	IF UNDER 24 HRS. Months 23 Days 23 Hours 23 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Window Decorator		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
11. BIRTHPLACE (State or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lundy W. Andrews		14. MOTHER'S MAIDEN NAME Margaret Rumpf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-34-0034	
17. INFORMANT L.W. Andrews		Address 428 W. Franklin St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 936.0 DUE TO Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO Coronary atherosclerosis (c) Longing			INTERVAL BETWEEN ONSET AND DEATH few minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Patient tied rope to head of bed			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year 2 7-20 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Hagerstown Washington Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE A. S. Smith		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DREW J. TITTO		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/23/59	22c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park	22d. LOCATION (City, town, or county) (State) Frederick Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR JUL 24 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 must be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
RECORDS



2411

DATE OF BIRTH
1911

DATE OF DEATH
1911

DATE OF BURIAL
1911

DATE OF INTERMENT
1911

DATE OF CREMATION
1911

DATE OF TRANSFER
1911

DATE OF REINTERMENT
1911

DATE OF REINTERMENT
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DATE OF REINTERMENT
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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF BIRTH
1911

DATE OF DEATH
1911

DATE OF BURIAL
1911

DATE OF INTERMENT
1911

DATE OF CREMATION
1911

DATE OF TRANSFER
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DATE OF REINTERMENT
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DATE OF DEATH
1911

DATE OF BURIAL
1911

DATE OF INTERMENT
1911

DATE OF CREMATION
1911

DATE OF TRANSFER
1911

DATE OF REINTERMENT
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8418

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROWNSVILLE</u>	
c. LENGTH OF STAY IN 1b <u>ONE WEEK</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELLEN</u> Middle <u>B.</u> Last <u>BACKUS</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY-11-1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>BROWNSVILLE WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DR. R. H. BOTELIER</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA HAMMOND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>LANGDON BACKUS BROWNSVILLE MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral and C. V. arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>5 Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic pneumonitisb- terminal</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May 19, 1959</u> , to <u>7/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/26/59</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter H. Shealy</u> M.D.		ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u> DATE SIGNED <u>July 27, 59</u>	
PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY-28-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. LUKES CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BROWNSVILLE WASH. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Paul</u> ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR <u>JUL 29 59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Arns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

A vertical strip of paper, likely a page from a binder or folder, showing four circular punch holes along its right edge. The paper is white and appears to be a scan of a physical document.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after the certificate has been signed by the attending physician and completed, should be filed with the FUNERAL DIRECTOR. After the certificate has been signed by the attending physician and completed, the certificate should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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8419

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>16 Maple Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rosa Delilah Barkdoll</u>				4. DATE OF DEATH Month Day Year <u>July 10 19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25, 1875</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Beaver Creek Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u></u>							
13. FATHER'S NAME <u>Joseph Kretsinger</u>				14. MOTHER'S MAIDEN NAME <u>Julia Weller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-----</u>				16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Mrs. Mable B. Bowman Smithsburg Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12-17-56</u> , 19 <u>56</u> , to <u>7-10-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-2-59</u> , 19 <u>59</u> , and that death occurred at <u>2:50a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Smithsburg Md.</u> DATE SIGNED <u>7-11-59</u>							
ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>				<u>Smithsburg Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 12, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u>				ADDRESS <u>Smithsburg Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 14 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

8467

CERTIFICATE OF DEATH

Items 8 & 9, Film G-246 8/6/59.cac.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN lb <u>9 mos. 5 days</u> <u>Williamsport</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>ROSS</u> Last <u>Betts</u>		4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1893</u> <u>April 13/1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Downsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert E. Betts</u>		14. MOTHER'S MAIDEN NAME <u>Lavinia Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219 36 4707</u>	
17. INFORMANT <u>Mrs. Claude Cline Williamsport Md RFD#1</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Williamsport</u>		(County) (State)	
21. I certify that I attended the deceased from <u>7/20/59</u> to <u>7/20/59</u> , that I last saw the deceased alive on <u>7/20/59</u> and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Williamsport, Md.</u> DATE SIGNED <u>7/20/59</u> ACTUAL SIGNATURE <u>N. F. Young</u> M.D. <u>Williamsport, Md.</u> PHYSICIAN'S NAME (Type) <u>N. F. Young</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 23 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leg Williamsport, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 23 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
TSM 9/58

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8420

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middletown</u> <u>10X-2</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Adam</u> Last <u>Bidle</u>				4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>19 59</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/30/1884</u>		9. AGE (In years lost birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner, ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George H. Bidle</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Virginia Tribbet, Middletown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Pyelonephritis</u> <u>6 weeks</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>7/3/59</u> , 19 <u>59</u> , to <u>7/3/</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>832 Potomac Ave., Hagerstown, Md.</u> DATE SIGNED <u>7-3-59</u>							
ACTUAL SIGNATURE <u>Jacob G. Warden</u> M.D.				832 Potomac Ave., Hagerstown, Md.			
PHYSICIAN'S NAME (Type) <u>Jacob G. Warden, M. D.</u>				832 Potomac Ave., Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7/5/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2480

1940

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1875		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. PLACE OF DEATH Home		14. DATE OF DEATH 1940		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF DECEASED James H. Harris		17. SIGNATURE OF WITNESSES John Doe, Jane Doe		18. SIGNATURE OF PHYSICIAN Dr. John Smith		19. SIGNATURE OF CLERK Mary White		20. SIGNATURE OF REGISTRAR John Black	

08399

8421

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>		c. LENGTH OF STAY IN 1b —	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>	
f. STREET ADDRESS <u>RD 4 - Hagerstown</u>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MIRIAM</u> First <u>A.</u> Middle <u>BIVENS</u> Last		4. DATE OF DEATH <u>July 18</u> Month <u>1959</u> Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/3/1902</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Aughinbaugh</u>		14. MOTHER'S MAIDEN NAME <u>Sarah GARNES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Homer L. Bivens</u>		Address <u>RD 4 Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June 18, 1959</u> , to <u>July 18, 1959</u> , that I last saw the deceased alive on <u>July 18, 1959</u> , and that death occurred at <u>10:40</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>Greencastle, Pa.</u> DATE SIGNED <u>7/20/59</u>	
PHYSICIAN'S NAME (Type) <u>Paul F. Webster, M.D.</u>		<u>Greencastle, Penna.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		22b. DATE THEREOF <u>7/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich</u>		ADDRESS <u>Greencastle, Pa.</u>	
24a. REC'D. BY REGISTRAR <u>JUL 22 1959</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.



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CERTIFICATE OF DEATH

08401

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TANEXTOWN</u> 06X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MARYLAND STATE Hosp.</u>		d. STREET ADDRESS <u>E. BALTO. ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Millie ELZENA BROWN</u>		4. DATE OF DEATH Month Day Year <u>July 3 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 27, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>SAMUEL BROWN</u>		14. MOTHER'S MAIDEN NAME <u>JULIA A. HITCHCOCK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT Address <u>Mr. Theron SPANGLER LITTLETOWN PA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>coronary atherosclerosis</u> DUE TO (c) <u>unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1) Fracture left hip, old. 2) Chronic pyelonephritis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall in home Aug. 1958</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>Aug. 10 1958</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Tanextown, Carroll, Maryland</u>
21. I certify that I attended the deceased from <u>May 11</u> , 19 <u>57</u> , to <u>July 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 3</u> , 19 <u>59</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Victor L. Ramos</u> M.D.		ADDRESS (Street, city or town, state) <u>Western Md. State Hospital</u> DATE <u>July 3, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Victor L. Ramos</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>TANEXTOWN MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>		24a. REC'D BY REGISTRAR <u>JUL 7 1959</u> DATE	
ADDRESS <u>Tanextown Md.</u>		24b. REGISTRAR'S SIGNATURE <u>John S. F...</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or other person authorized by the law, should be notified. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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CERTIFICATE OF DEATH

1925

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[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. The text appears to be a form with various fields and lines for information.]

8423

CERTIFICATE OF DEATH

Reg. Dist. No. 08402

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BIG SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON CO HOSPITAL</u>		d. STREET ADDRESS <u>RD # 1</u>	
3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>LESLIE</u> Last <u>BURKETT</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Road Bldg</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Wesley Burkett</u>		14. MOTHER'S MAIDEN NAME <u>Alice Lamison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-12-7193</u>	
17. INFORMANT <u>Grace Burkett</u> Address <u>Big Springs Md Rd #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR HEMORRHAGE WITH RIGHT</u> <u>443X</u> DUE TO HEMIPLEGIA Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>POSSIBLE CARCINOMA OF THE LEFT LUNG.....</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>APRIL 7, 1959</u> , 19____ to <u>JULY 7, 1959</u> , 19____, that I last saw the deceased alive on <u>JULY 7, 1959</u> , 19____, and that death occurred at <u>6:13 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>ARCHIE ROBERT COHEN, M.D.</u>		<u>CLEAR SPRING, MARYLAND JULY 8, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	22b. DATE THEREOF <u>July 10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brandsfording</u>	22d. LOCATION (City, town, or county) (State) <u>Washington Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Munnell</u> ADDRESS <u>Greencastle Pa</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
RESIDENCE		BIRTHPLACE		EDUCATION		MARRIAGE		SINGLE	
FATHER'S NAME		MOTHER'S NAME		BROTHERS		SISTERS		CHILDREN	
PREVIOUS ILLNESS		TREATMENT		HISTORY		SYMPTOMS		DIAGNOSIS	
DATE OF BURIAL		PLACE OF BURIAL		CEREMONY		COST		FUNERAL HOME	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER	
DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF SIGNATURE	

8424

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS 39 E. Salisbury St.	
3. NAME OF DECEASED (Type or print) First Roth Middle Albert Last Castle		4. DATE OF DEATH Month July Day 9 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1 1882
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 8 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Aircraft	
11. BIRTHPLACE (State or foreign country) Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Gruber Castle		14. MOTHER'S MAIDEN NAME Florence Farrow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215 01 9832	
17. INFORMANT Mr. Edward Castle		18. ADDRESS 39 E. Salisbury St. Williamsport Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Codounaly Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH Day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/9/59 , 19 59 , to 7/9/59 , that I last saw the deceased alive on 7/9/59 , 19 59 , and that death occurred at 10:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Williamsport Md. DATE SIGNED 7/10/59			
ACTUAL SIGNATURE L. E. Young		M.D. Williamsport Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 12-59	
22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edith U. Leaf Williamsport Md.		24a. REC'D BY REGISTRAR DATE JUL 13 59	
24b. REGISTRAR'S SIGNATURE Colton L. Knaus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3424

CERTIFICATE OF

WILLIAMSON

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08404

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8469

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport, c. LENGTH OF STAY IN 1b 13 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) rr 7 E. Church Street				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport d. STREET ADDRESS 114 S. Conococheague Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Elmer Last Cavender				4. DATE OF DEATH Month July Day 17 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1893	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 0 Days 23		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Penna	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Jesse Cavender				14. MOTHER'S MAIDEN NAME Mary Ann Crawford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. # 1 212-38-9601		17. INFORMANT Address Mrs. Bertha Cavender- 114 S. Conococheague St Williamsport, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound thru skull and brain tissue DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause, stating the underlying (c) 976X							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head with 22 pistol					
20c. TIME OF INJURY Month, Day, Year Hour 12:15 a.m. July 17 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Williamsport, Wash. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 20-59		22c. NAME OF CEMETERY OR CREMATORY Fairview Christian Church Cemetery		22d. LOCATION (City, town, or county) (State) Near Bellegrove Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Edith V. Leaf Williamsport Md.				24a. REC'D BY REGISTRAR DATE JUL 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Travis	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, cremation or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		45		1907		Maryland		Baltimore		Maryland		United States	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH	
Carpenter		High School		Roman Catholic		Married		None		None		Heart Disease		Natural	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		SIGNS OF LIFE	
April 15, 1954		10:30 AM		Home		98.6		72		20		120/80		None	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE		CITY		STATE		COUNTRY		REMARKS	
J. H. HARRIS		Physician		April 15, 1954		Baltimore		Maryland		United States		None		None	

8425

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 552 Salem Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE BELLE CEARFOSS				4. DATE OF DEATH Month Day Year July 11 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1882	
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rooming House Operator		11. BIRTHPLACE (State or foreign country) State Line, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George B. Bonebrake				14. MOTHER'S MAIDEN NAME Mary Carson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-34-0193		17. INFORMANT Address Mrs. Nellie Fleagle Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Hypertension							INTERVAL BETWEEN ONSET AND DEATH Immediate 3 yrs. 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov 2 , 19 55 , to July 11 , 19 59 , that I last saw the deceased alive on June 26th , 19 59 , and that death occurred at 7:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 159 W. Washington St., Hagerstown, Md. DATE SIGNED 7/13/59							
ACTUAL SIGNATURE Philip J. Hirshman				PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/14/1959		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Kouzer Funeral Home K. Franklin Kouzer				ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR DATE JUL 15 '59	
				24b. REGISTRAR'S SIGNATURE Charles S. Frank			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 100

Registration

Death

Age

Sex

Marital Status

Occupation

Education

Place of Birth

Place of Death

Cause of Death

Date of Death

Time of Death

Place of Death

Place of Death

Signature

Signature

Date of Death

Date of Death

Date

8470

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 4		c. LENGTH OF STAY IN 1b 45 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Broadfording Road		/d. STREET ADDRESS Broadfording Road	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CORNELIA Middle KATE Last CHAPMAN		4. DATE OF DEATH Month July Day 13 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 7 1881
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Middleburg Franklin Co Pa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Muritz		14. MOTHER'S MAIDEN NAME Susanna Swisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Edgar G. Chapman Hagerstown R #4		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerotic Heart Disease (c) INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-20 , 19 59 , to 7-13 , 19 59 , that I last saw the deceased alive on 7-13-59 , 19 59 , and that death occurred at 4:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. E. Coffman		ADDRESS (Street, city or town, state) Hagerstown Md	
DATE SIGNED 7/14/59			
PHYSICIAN'S NAME (Type) DREW L. G. T. J.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/16/59	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JUL 17 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. King	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2070

NAME OF DECEASED [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		DATE OF BIRTH [REDACTED]	
PLACE OF BIRTH [REDACTED]		PLACE OF DEATH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF CORONER [REDACTED]	
SIGNATURE OF JUDGE [REDACTED]		SIGNATURE OF CLERK [REDACTED]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8426 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08407

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <u>Maryland</u> <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 Hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairchild Aircraft Plant</u>			d. STREET ADDRESS <u>137 E. Antietam St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ELMER NMN CHONES</u>			4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4 1902</u>		9. AGE (In years last birthday) <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild</u>		11. BIRTHPLACE (State or foreign country) <u>Chicago Cook Co Ill</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Abraham Chones</u>			14. MOTHER'S MAIDEN NAME <u>Jenny (Unknown)</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W.# 2 218-24-8841</u>		17. INFORMANT <u>Katherine R. Chones</u> Address <u>137 E. Antietam St Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>976x Gun shot wound into chest - hemorrhage and shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in chest with 38 revolver</u>			
20c. TIME OF INJURY Month, Day, Year <u>5:30 a.m. July 7 1959</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Factory</u>	
		20f. (City or town) <u>Hagerstown</u>		(County) <u>Wash</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-7-59</u>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Hagerstown Wash. Co Md</u>		22e. (State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneib</u>	

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-1-53

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
EDUCATION: [illegible]
MARRIAGE: [illegible]
RELIGION: [illegible]
PREVIOUS ILLNESS: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate should be filed with the funeral director. After this certificate has been signed by the attending physician and complete, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8427
CERTIFICATE OF DEATH

08408

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Swanton HAGERSTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SYLVIA</u> Middle <u>Mae</u> Last <u>DAVIS</u>		4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1897</u>
9. AGE (In years last birthday) yrs. <u>61</u>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Henry, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Farris</u>		14. MOTHER'S MAIDEN NAME <u>Florence Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>William E. Davis, Swanton, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-22-59</u> , 19 <u>59</u> to <u>7-24-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-24-59</u> , 19 <u>59</u> , and that death occurred at <u>6:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. Boyer</u>		ADDRESS (Street, city or town, state) <u>135 No. Potomac St. Swanton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		DATE SIGNED <u>7-24-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 28, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Virts Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Garrett Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Boal</u>		ADDRESS <u>Westernport, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 3427
 CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 1928		6. BIRTH PLACE Mississippi	
7. DECEASED DATE April 4, 1968		8. DECEASED TIME 2:01 PM		9. DECEASED PLACE Room 306, Airport Hotel, Memphis, Tennessee	
10. DECEASED CAUSE Heart Disease		11. DECEASED DISEASE Coronary Artery Disease		12. DECEASED SYMPTOMS Chest pain, shortness of breath	
13. DECEASED HISTORY No previous history of heart disease		14. DECEASED TREATMENT None		15. DECEASED MEDICATION None	
16. DECEASED SIGNATURE James Earl Ray		17. DECEASED ADDRESS Room 306, Airport Hotel, Memphis, Tennessee		18. DECEASED CITY Memphis, Tennessee	
19. DECEASED STATE Tennessee		20. DECEASED COUNTY Shelby		21. DECEASED ZIP 38103	
22. DECEASED MARITAL STATUS Single		23. DECEASED OCCUPATION None		24. DECEASED EDUCATION High School	
25. DECEASED RELIGION None		26. DECEASED ETHNICITY None		27. DECEASED ANCESTRY None	
28. DECEASED SOCIAL SECURITY None		29. DECEASED MARRIAGE None		30. DECEASED CHILDREN None	
31. DECEASED SPOUSE None		32. DECEASED PARENTS None		33. DECEASED SIBLINGS None	
34. DECEASED GRANDPARENTS None		35. DECEASED GREAT-GRANDPARENTS None		36. DECEASED OTHER RELATIVES None	
37. DECEASED SIGNATURE James Earl Ray		38. DECEASED ADDRESS Room 306, Airport Hotel, Memphis, Tennessee		39. DECEASED CITY Memphis, Tennessee	
40. DECEASED STATE Tennessee		41. DECEASED COUNTY Shelby		42. DECEASED ZIP 38103	
43. DECEASED MARITAL STATUS Single		44. DECEASED OCCUPATION None		45. DECEASED EDUCATION High School	
46. DECEASED RELIGION None		47. DECEASED ETHNICITY None		48. DECEASED ANCESTRY None	
49. DECEASED SOCIAL SECURITY None		50. DECEASED MARRIAGE None		51. DECEASED CHILDREN None	
52. DECEASED SPOUSE None		53. DECEASED PARENTS None		54. DECEASED SIBLINGS None	
55. DECEASED GRANDPARENTS None		56. DECEASED GREAT-GRANDPARENTS None		57. DECEASED OTHER RELATIVES None	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8428 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 9 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. Co. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
f. STREET ADDRESS 6511 Baltimore Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gilbert Allen Dukeman		4. DATE OF DEATH Month 7 Day 20 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1929
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	
11. BIRTHPLACE (State or foreign country) Altoona, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert A. Dukeman		14. MOTHER'S MAIDEN NAME Catherine Isabell Cramer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. 182-22-1400	
17. INFORMANT Robert A. Dukeman		Address Altoona, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dislocation rt hip; Closed fracture lt femur; 816 X DUE TO Multiple fractures of pelvic bones; Multiple fracture ribs; Intra-abdominal injuries-Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Shock (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto that was involved in head-on collision	
20c. TIME OF INJURY Month, Day, Year 6:30 AM July 19 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Rural- Clearspring Wash Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-22-59	
22c. NAME OF CEMETERY OR CREMATORY Bald Eagle		22d. LOCATION (City, town, or county) (State) Curtin Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE JUL 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
2222 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death	
John Doe		45		Male		White		10/15/1918	
Place of Birth		Residence		Occupation		Cause of Death		Manner of Death	
New York, N.Y.		1234 Main St., Baltimore, Md.		Teacher		Heart Disease		Natural	
Date of Birth		Date of Admission to Hospital		Date of Discharge		Date of Death		Date of Burial	
10/10/1873		10/12/1918		10/14/1918		10/15/1918		10/16/1918	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Date of Certificate		Date of Burial		Date of Interment		Date of Cremation	
10/16/1918		10/16/1918		10/16/1918		10/16/1918		10/16/1918	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08410

8471

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT.#2 HAGERSTOWN		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN	
3. NAME OF DECEASED (Type or print) HELEN First VIRGINIA Middle EBY Last		4. DATE OF DEATH JULY Month 9 Day 19 Year 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/30/1912
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDGAR STRITE		14. MOTHER'S MAIDEN NAME MARY M. MARTIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. IRA E. EBY		RT.# 2 Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 175.0 IMMEDIATE CAUSE (a) metastatic cancer DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Choke of ovary DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/2/58 , 19____, to 7/9/59 , 19____, that I last saw the deceased alive on 7/7/59 , 19____, and that death occurred at 2A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 North Potomac St. Hagerstown, Maryland DATE SIGNED 7/10/59			
ACTUAL SIGNATURE Howard N. Weeks, M.D.		M.D. 136 North Potomac St. Hagerstown, Maryland	
PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/12/59	22c. NAME OF CEMETERY OR CREMATORY REIFFS MENNONITE CHURCH	22d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE A.E. Minnich, Greenbelt, Penn.		24a. REC'D BY REGISTRAR AUG 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08411

8429

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro 75 x 3	
c. LENGTH OF STAY IN 1b 16 Hours		d. STREET ADDRESS 333 Fairview Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Cora Funk Fahrney		4. DATE OF DEATH Month Day Year July 2 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/5/1871
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Duties		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Waynesboro Pa., #2		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin S. Funk		14. MOTHER'S MAIDEN NAME Elizabeth Sarbaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Floyd Fahrney, 333 Fairview Ave., Waynesboro Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apoplexy 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr. yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2, 19 59, to July 2, 19 59, that I last saw the deceased alive on July 1, 19 59, and that death occurred at 2:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE D. J. Boyer		ADDRESS (Street, city or town, state) 135 North Potomac Street	
DATE SIGNED			
PHYSICIAN'S NAME (Type) D. J. BOYER, M. D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/4/59	
22c. NAME OF CEMETERY OR CREMATORY Green Hill		22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walter Z. Grove, Waynesboro Pa.		24a. REC'D BY REGISTRAR DATE JUL 6 59	
24b. REGISTRAR'S SIGNATURE			

8430

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. STREET ADDRESS 1 114 Allen Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pearley Middle Victor Last Ford		4. DATE OF DEATH Month July Day 31 , Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1874
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 8 Days 1 Hours 1 Min.	11. IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner		10b. KIND OF BUSINESS OR INDUSTRY rug and novelty store	
11. BIRTHPLACE (State or foreign country) Harmonsburg, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Ford		14. MOTHER'S MAIDEN NAME Sally A. Henry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Edwin C. Ford, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Nephrosclerosis DUE TO 2-3 yr (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/23 , 19 59 , to 7/31 , 19 59 , that I last saw the deceased alive on 7/23 , 19 59 , and that death occurred at 12P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert T. H. Campbell M.D.		ADDRESS (Street, city or town, state) Hagerstown Md DATE SIGNED 7/31/59	
PHYSICIAN'S NAME (Type) Robert T. H. Campbell		145 W Washington St	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Aug. 3, 1959	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Conneaut, Ohio.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE AUG 3 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

2430

CITY OF NEW YORK

0-113

IN SENATE

January 10, 1917

REPORT OF THE COMMISSIONER OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

APRIL 21, 1916

1917

ALBANY

WILEY

PRINTED BY THE COMMISSIONER OF THE LAND OFFICE

1917

James Lord

none

DC

Office of the Commissioner of the Land Office

Printed by the Commissioner of the Land Office

Albany, New York, 1917

8431

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08413

Reg. Dist. No. 302

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 1 1/2 Hrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg R # 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. County Hospital		d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LINDA MAY FULTZ		4. DATE OF DEATH Month July Day 30 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 11 1958
9. AGE (in years last birthday) 9 yrs.		IF UNDER 1 YEAR Months 9 Days 9	IF UNDER 24 HRS. Hours 9 Min. 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Junior Daley Fultz		14. MOTHER'S MAIDEN NAME Ruby Haines	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Junior D. Fultz		Address Sharpsburg Md. R # 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Skull + of Humerus 9040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 3 hours
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fell while mother was bathing child	
20c. TIME OF INJURY Month, Day, Year 6 Hour 7-30 a. m. 7-30 p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Sharpsburg Wash Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE A. E. W. Smith		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. F. W. Ditto Jr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/1/59	
22c. NAME OF CEMETERY OR CREMATORY Salem Church Cemetery		22d. LOCATION (City, town, or county) (State) Slanesville Hampshire Co W. Va	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagersyown Md.	
24a. REC'D BY REGISTRAR AUG 3 '59		24b. REGISTRAR'S SIGNATURE Charles S. Frazier	

2081214XV3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

—

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after this certificate has been signed by the attending physician and completed, filled in, and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Washington Md</i> 8473 <i>MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>443 1/2 Cumberland</i> b. COUNTY <i>Cumberland Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hancock Res Home</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hancock Res Home</i>		d. STREET ADDRESS <i>Hancock Md</i>	
3. NAME OF DECEASED (Type or print) <i>David Haller</i>		4. DATE OF DEATH <i>7-23-59</i> <i>9 19 59</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3:30 P 3-17-1879</i>
9. AGE (In years last birthday) <i>80</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer to 7-10-58</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Enterprise</i>	
11. BIRTHPLACE (State or foreign country) <i>Piney Grove Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Mr Henry Haller</i>		14. MOTHER'S MAIDEN NAME <i>Roberts</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Not</i>		16. SOCIAL SECURITY NO. <i>234 301363</i>	
17. INFORMANT <i>Frank B Thomas Jr M. D.</i>		Address <i>Hancock, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Congestive Heart Failure</i> DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>30 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pneumonia, Right Parotid Abscess.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 27</i> , 19 <i>57</i> , to <i>July 23</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>July 23</i> , 19 <i>59</i> , and that death occurred at <i>9:15 P M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank B Thomas Jr M. D.</i>		DATE SIGNED <i>7-23-59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/25/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Cumberland Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc.</i>		ADDRESS <i>Cumb. Md</i>	
24a. REC'D BY REGISTRAR <i>DATE 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

8473

DEATH
IN
HOSPITAL

AD 1

1. Name of deceased: *John Doe*
 2. Sex: *Male*
 3. Age: *45*
 4. Date of birth: *1910-01-15*
 5. Place of birth: *New York City*
 6. Date of death: *1955-03-10*
 7. Time of death: *10:30 AM*
 8. Place of death: *St. Mary's Hospital*
 9. Cause of death: *Myocardial Infarction*
 10. Physician: *Dr. J. Smith*
 11. Burial place: *St. Mary's Cemetery*
 12. Burial date: *1955-03-12*
 13. Burial time: *11:00 AM*
 14. Burial place: *St. Mary's Cemetery*
 15. Burial date: *1955-03-12*
 16. Burial time: *11:00 AM*
 17. Burial place: *St. Mary's Cemetery*
 18. Burial date: *1955-03-12*
 19. Burial time: *11:00 AM*
 20. Burial place: *St. Mary's Cemetery*
 21. Burial date: *1955-03-12*
 22. Burial time: *11:00 AM*
 23. Burial place: *St. Mary's Cemetery*
 24. Burial date: *1955-03-12*
 25. Burial time: *11:00 AM*
 26. Burial place: *St. Mary's Cemetery*
 27. Burial date: *1955-03-12*
 28. Burial time: *11:00 AM*
 29. Burial place: *St. Mary's Cemetery*
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 31. Burial time: *11:00 AM*
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 190. Burial time: *11:00 AM*
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 193. Burial time: *11:00 AM*
 194. Burial place: *St. Mary's Cemetery*
 195. Burial date: *1955-03-12*
 196. Burial time: *11:00 AM*
 197. Burial place: *St. Mary's Cemetery*
 198. Burial date: *1955-03-12*
 199. Burial time: *11:00 AM*
 200. Burial place: *St. Mary's Cemetery*

8432

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 4 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLYDE ORVAL HARBAUGH				4. DATE OF DEATH Month Day Year July 25 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 28 1877	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Md. Chewsville Wash. Co	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John I. Harbaugh				14. MOTHER'S MAIDEN NAME Martha A. Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Jesse H. Harbaugh		Address 62 E. Irvin Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Prostate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 18, 1959 to July 25, 1959 , that I last saw the deceased alive on July 24, 1959 , and that death occurred at 3:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert P. Conrad M.D.				ADDRESS (Street, city or town, state) 137 W Washington		DATE SIGNED 7-25-59	
PHYSICIAN'S NAME (Type) Robert P. Conrad				Hagerstown, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/27/59		22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JUL 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kress			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8338

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. Code No. 000

<p>NAME OF DECEASED JAMES H. HARRIS</p>		<p>AGE 65</p>	
<p>SEX Male</p>		<p>RACE White</p>	
<p>DATE OF DEATH May 15, 1957</p>		<p>PLACE OF DEATH Home</p>	
<p>CAUSE OF DEATH Myocardial Infarction</p>		<p>DATE OF BIRTH May 15, 1957</p>	
<p>PLACE OF BIRTH Baltimore, Md.</p>		<p>DATE OF DEATH May 15, 1957</p>	
<p>DATE OF DEATH May 15, 1957</p>		<p>PLACE OF DEATH Home</p>	
<p>CAUSE OF DEATH Myocardial Infarction</p>		<p>DATE OF BIRTH May 15, 1957</p>	
<p>PLACE OF BIRTH Baltimore, Md.</p>		<p>DATE OF DEATH May 15, 1957</p>	
<p>DATE OF DEATH May 15, 1957</p>		<p>PLACE OF DEATH Home</p>	
<p>CAUSE OF DEATH Myocardial Infarction</p>		<p>DATE OF BIRTH May 15, 1957</p>	
<p>PLACE OF BIRTH Baltimore, Md.</p>		<p>DATE OF DEATH May 15, 1957</p>	

RECEIVED
 MAY 16 1957
 BALTIMORE, MD

08417

MARYLAND STATE DEPARTMENT OF HEALTH

8474

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

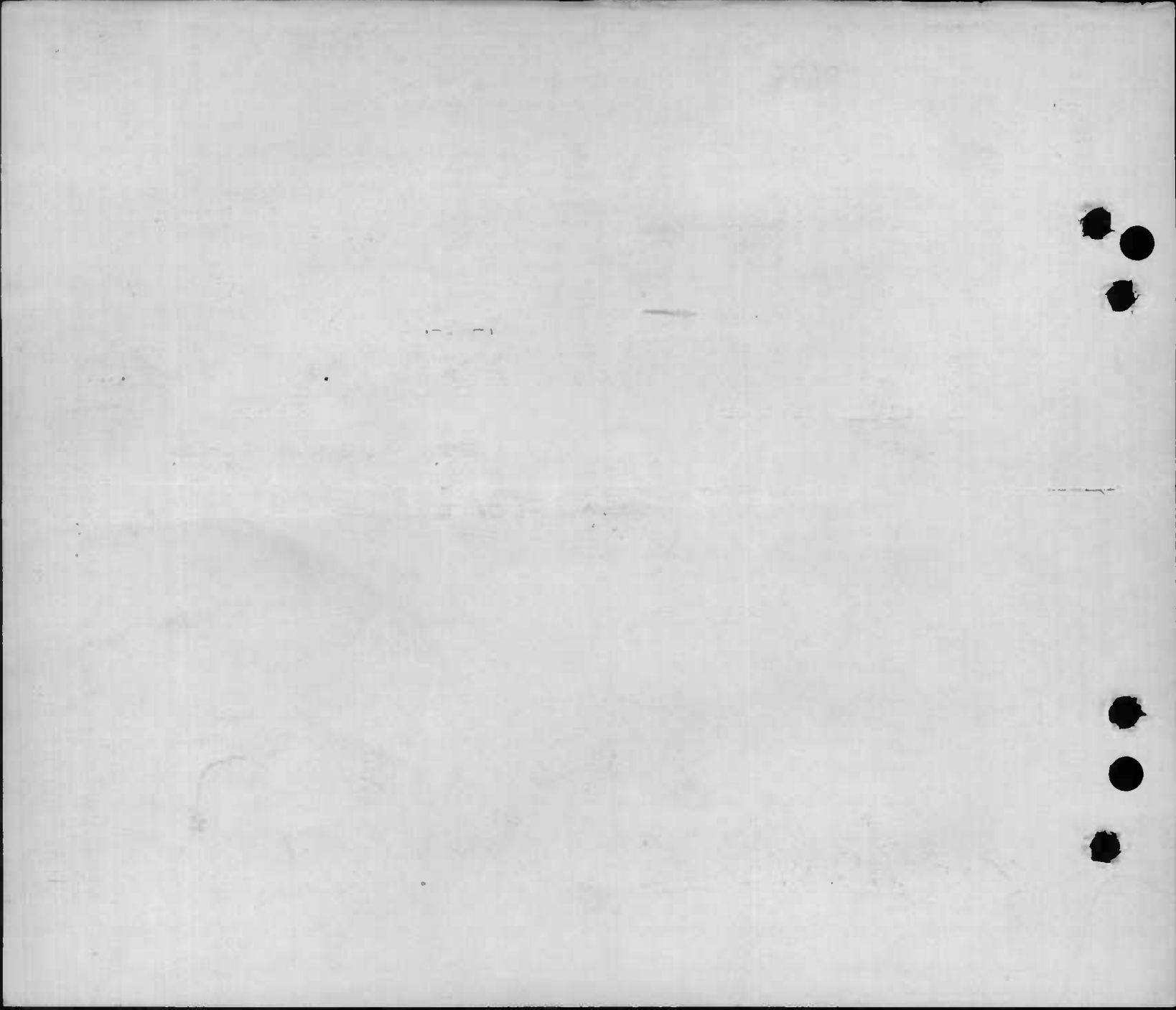
Reg. Dist. No.

1. PLACE OF DEATH COUNTY WASH MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wash	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Williamsport		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Williamsport	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Home		STREET ADDRESS Rt# 11 (If rural, give location)	
3. NAME OF DECEASED (Type or Print) INEZ (First) M. (Middle) HAY (Last)		4. DATE OF DEATH (Month) 7 (Day) 27 (Year) 1959	
5. SEX F	6. COLOR OR RACE W	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Jan 17 - 1971 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home	9. AGE last birthday 88 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Berlin Pa.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Daniel Altfather		14. MOTHER'S MAIDEN NAME Malinda Walker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mrs. Margaret Wagner		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause (a) Cardiovascular Collapse			min
Antecedent cause(s) (b) Arteriosclerosis Gen			yrs.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Cardiac			months
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 19 59 , to July 27 19 59 , that I last saw the deceased alive on July 21 19 59 , and that death occurred at 12 15 a.m., from the causes and on the date stated above.			
SIGNATURE J. Arthur Walters		ADDRESS MD 119 E. Antietam Hagerstown	
DATE SIGNED July 30 - 59			
23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE THEREOF July 30 - 59	
NAME OF CEMETERY OR CREMATORY St. Luke's		LOCATION (City, town, or county) (State) Williamsport Pa. MD	
24. FUNERAL DIRECTOR J. Arthur Walters		ADDRESS 254 Carroll St. D.C.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGUL 29 59			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. The funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8433

CERTIFICATE OF DEATH

08418

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nagerstown</u>	c. LENGTH OF STAY IN 1b <u>1 1/2 Days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle (Rural)</u> 75X.3	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Wash. Co. Hospital</u>		e. STREET ADDRESS <u>Greencastle RD3</u>	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MILDRED C. HELMAN</u>		4. DATE OF DEATH Month Day Year <u>July 29 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/31/1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Zullinger, Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>IRA B. FAHRNEY</u>	
14. MOTHER'S MAIDEN NAME <u>ELLA NEWCOMER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ray Helman - RD3</u> Address <u>Greencastle, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>ADDED CARCINOMA OF BREAST &</u> DUE TO <u>24YRS -</u> (c) <u>METASTASIS -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1956</u> 19... to <u>29 July 1959</u> , that I last saw the deceased alive on <u>July 29, 1959</u> , and that death occurred at <u>9:22</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Greencastle Pa.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Paul F. Webster</u>		M.D. <u>GREENCASTLE PA.</u>	
PHYSICIAN'S NAME (Type) <u>Paul F. Webster, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>	22b. DATE THEREOF <u>Aug 1, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Minnich - Greencastle, Pa.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8475 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08419

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ----		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brethedsville		c. LENGTH OF STAY IN 1b 2 Mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3 Vol-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md State Reformatory for Males			d. STREET ADDRESS 15293 Myrtle St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Samuel Middle NMN Last Howard Jr			4. DATE OF DEATH Month July Day 11 Year 1959		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1 1942		9. AGE (In years last birthday) 17 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Baltimore City Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel Howard Sr			14. MOTHER'S MAIDEN NAME Mary Carter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Records of State Reformatory for Males Brethedsville Wash. Co. Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Asphyxia by hanging DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 2 Hour o. m. July 11 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Institution	
		20f. (City or town) Rural Hagerstown, Wash Md		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-11-59	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15/59		22c. NAME OF CEMETERY OR CREMATORY Mt Albans Cemetery	
				22d. LOCATION (City, town, or county) (State) Baltimore City Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman			ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JUL 14 '59
					24b. REGISTRAR'S SIGNATURE Robert S. H... ..

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8476

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO RURAL</u>		c. LENGTH OF STAY IN 1b <u>13 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BOONSBORO RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOONSBORO MD. R. 2</u>				d. STREET ADDRESS <u>1 BOONSBORO MD. R. 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>OTTO J. HUTZELL</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY - 9 - 1888</u>	9. AGE (In years lost birthday) yrs. <u>71</u>		IF UNDER 1 YEAR: Months <u>6</u> Days <u>15</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTH PLACE (State or foreign country) <u>ZITTELSTOWN WASH. Co. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL HUTZELL</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE LAPOLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNAVAILABLE</u>		17. INFORMANT <u>MRS. RHODA DELAUTER BOONSBORO MD. R. 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease with</u> <u>420.0</u> DUE TO <u>Myocardial Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u></u> p. m. <u></u>	Month <u></u> Day <u></u> Year <u>1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>Feb</u> <u>1946</u> , to <u>July 25</u> <u>1959</u> , that I last saw the deceased alive on <u>8 July</u> <u>1959</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F F Lusby</u>		M.D. <u>230 N Potomac</u>		ADDRESS (Street, city or town, state) <u>Hagerstown Md</u>		DATE SIGNED <u>25 July 59</u>	
PHYSICIAN'S NAME (Type) <u>F F Lusby</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 27 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				ADDRESS <u>BOONSBORO MD.</u>		24d. REC'D BY REGISTRAR <u>JUL 29 59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knease</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2043

FROM MID

Blank form with horizontal lines for text entry.



8434

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mass. b. COUNTY Suffolk			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Saugus 58x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 5 Treher Street			
3. NAME OF DECEASED (Type or print) First IRVING Middle P. Last JOHNSON				4. DATE OF DEATH Month July Day 20 Year 19 59			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-21-1908	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Orleans, Louisiana	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jewell Johnson				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Davis Funeral Home Boston, Mass.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION DUE TO (c) CORONARY ATHEROSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES 25 DAYS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ESSENTIAL HYPERTENSION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-26 , 19 59 , to 7-20 , 19 59 ; that I last saw the deceased alive on 7-20-59 , 19 59 , and that death occurred at 6:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John D. Torco				ADDRESS (Street, city or town, state) 302 N. POTOMAC ST		DATE SIGNED 7-21-59	
PHYSICIAN'S NAME (Type) JOHN D. TORCO				HAGERSTOWN, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/1959		22c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery		22d. LOCATION (City, town, or county) (State) Saugus Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Houzer Funeral Home				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUL 23 '59	
				24b. REGISTRAR'S SIGNATURE Arthur J. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Age of Deceased

Sex

Color

Married

Place of Birth

Date of Death

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

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ORIGINAL

1

8477

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Jefferson</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nagerstown Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD. Shenandoah Junction</u>	
c. LENGTH OF STAY IN 1b <u>4 mo</u>		d. STREET ADDRESS <u>85x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Conv. Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Columbus</u> First <u>Washington</u> Middle <u>Jones</u> Last		4. DATE OF DEATH <u>July 21, 1959</u> Month <u>July</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1874</u> 9. AGE (In years last birthday) <u>85</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer on Farm and Orchard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clarke County, Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Alfred Jones, (dec)</u>		14. MOTHER'S MAIDEN NAME <u>Susan (Unknown) (dec)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. George Diehl (Niece) Charles Town.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line (or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 20, 1959</u> to <u>July 21, 1959</u> , that I last saw the deceased alive on <u>July 20, 1959</u> , and that death occurred at <u>9:00 A.M.</u> (from the causes and on the date stated above).			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md</u> DATE SIGNED <u>7/22/59</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 24, '59.</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salem Churchyard</u>		22d. LOCATION (City, town, or county) (State) <u>Salem, Va. (Loudoun Co) Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malvin T. Stinder</u> ADDRESS <u>Charles Town W Va</u>		24a. REC'D BY REGISTRAR <u>JUL 28 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital pending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

31 West 12th St.
Boston, Mass.
July 21, 1924

Male White
Age 21
Date of Birth July 21, 1903

Heart Failure
General Debility
10 yrs.

David R. Brewer
Clear Spring Md 7/21/24
July 21, 1924

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08423

8435

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>60yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>127 E. Lee Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>Dewey</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 5, 1898</u>		9. AGE (In years lost birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Alvey Jones</u>				14. MOTHER'S MAIDEN NAME <u>Anne Seville Boyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>717-07-9300</u>		17. INFORMANT Address <u>Catherine V. Jones 127 E. Lee St. Hagerstown,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Bronchogenic carcinoma, right lung, with mediast-</u> DUE TO <u>inal metastasis</u> (c)						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 29, 1958</u> to <u>July 5, 1959</u> , that I last saw the deceased alive on <u>July 5, 1959</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>131 W. Washington Street, Hagerstown, Md.</u> DATE SIGNED <u>July 5, 1959</u>							
ACTUAL SIGNATURE <u>John H. Kehue</u> M.D.				PHYSICIAN'S NAME (Type) <u>John H. Kehue M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 8, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Boash</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 8 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hogue</u>			

CERTIFICATE OF DEATH

1937

<p>NAME OF DECEASED ALICE M. BROWN</p>		<p>AGE 65</p>		<p>SEX F</p>		<p>RACE W</p>	
<p>DATE OF DEATH JAN 15 1937</p>		<p>TIME OF DEATH 10:30 AM</p>		<p>PLACE OF DEATH HOME</p>		<p>CITY BALTIMORE</p>	
<p>CAUSE OF DEATH HEART DISEASE</p>		<p>IMMEDIATE CAUSE CORONARY THROMBOSIS</p>		<p>UNDERLYING CAUSE HYPERTENSION</p>		<p>OTHER CAUSE NONE</p>	
<p>DATE OF BIRTH MAY 15 1871</p>		<p>PLACE OF BIRTH BALTIMORE</p>		<p>EDUCATION HIGH SCHOOL</p>		<p>OCCUPATION HOUSEWIFE</p>	
<p>DATE OF MARRIAGE JUN 15 1895</p>		<p>NAME OF SPOUSE JOHN B. BROWN</p>		<p>DATE OF MARRIAGE JUN 15 1895</p>		<p>NAME OF SPOUSE JOHN B. BROWN</p>	
<p>DATE OF DEATH JAN 15 1937</p>		<p>TIME OF DEATH 10:30 AM</p>		<p>PLACE OF DEATH HOME</p>		<p>CITY BALTIMORE</p>	
<p>CAUSE OF DEATH HEART DISEASE</p>		<p>IMMEDIATE CAUSE CORONARY THROMBOSIS</p>		<p>UNDERLYING CAUSE HYPERTENSION</p>		<p>OTHER CAUSE NONE</p>	
<p>DATE OF BIRTH MAY 15 1871</p>		<p>PLACE OF BIRTH BALTIMORE</p>		<p>EDUCATION HIGH SCHOOL</p>		<p>OCCUPATION HOUSEWIFE</p>	
<p>DATE OF MARRIAGE JUN 15 1895</p>		<p>NAME OF SPOUSE JOHN B. BROWN</p>		<p>DATE OF MARRIAGE JUN 15 1895</p>		<p>NAME OF SPOUSE JOHN B. BROWN</p>	

8436

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLIK Middle NMN Last KAPLAN		4. DATE OF DEATH Month July Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12 1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Labin Kaplan		14. MOTHER'S MAIDEN NAME Mary (No Record)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Goldie Kaplan		Address 702 Marshall St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hagerstown Maryland INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-3 , 19 59 , to 7-18 , 19 59 , that I last saw the deceased alive on 7-18 , 19 59 , and that death occurred at 10:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John D. Turco		ADDRESS (Street, city or town, state) 302 N. Polemar St Hagerstown Md	
PHYSICIAN'S NAME (Type) JOHN D. TURCO		DATE SIGNED 7/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/20/59	22c. NAME OF CEMETERY OR CREMATORY B'Nai Abraham Cemetery Hagerstown Wash Co Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE JUL 21 '59		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8433

<p>1. NAME OF DECEASED JAMES EARL RAY</p>		<p>2. SEX MALE</p>	
<p>3. AGE 35</p>		<p>4. DATE OF BIRTH JAN 5 1928</p>	
<p>5. PLACE OF BIRTH MOBILE, ALABAMA</p>		<p>6. OCCUPATION MEMBER OF CONGRESS</p>	
<p>7. MARITAL STATUS SINGLE</p>		<p>8. DATE OF DEATH APR 4 1968</p>	
<p>9. TIME OF DEATH 2:01 PM</p>		<p>10. PLACE OF DEATH MEMPHIS, TENNESSEE</p>	
<p>11. CAUSE OF DEATH HEART DISEASE</p>		<p>12. MANNER OF DEATH ACCIDENTAL</p>	
<p>13. SIGNATURE OF PHYSICIAN [Signature]</p>		<p>14. SIGNATURE OF REGISTRAR [Signature]</p>	
<p>15. SIGNATURE OF WITNESS [Signature]</p>		<p>16. SIGNATURE OF WITNESS [Signature]</p>	

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8437
CERTIFICATE OF DEATH

08425

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN lb 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport RFD #2		d. STREET ADDRESS Pinesburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Bell Last Keeney		4. DATE OF DEATH Month July Day 15 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23 1894
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 3 Days 21 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Jacob Wetzel		14. MOTHER'S MAIDEN NAME Christina Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. James Leslie Keeney		Address Williamsport Md. RFD #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage due to arteriosclerosis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c) Art. sclerosis Heart disease		INTERVAL BETWEEN ONSET AND DEATH 7-13-59 1937	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 13, 1959 , to July 15, 1959 , that I last saw the deceased alive on July 15, 1959 , and that death occurred at 9:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE SIDNEY NOVENSTEIN M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Williamsport Md 7-16-59	
PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 18-59	
22c. NAME OF CEMETERY OR CREMATORY Rockyhill Cemetery		22d. LOCATION (City, town, or county) (State) Near Woodsboro Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Adrian Britton		ADDRESS WILLIAMSBURG MD	
24a. REC'D BY REGISTRAR JUL 20 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hunt	

3232

CERTIFICATE OF DEATH

1. Name of deceased: *William J. Williams*
2. Sex: *Male*
3. Age: *45*
4. Date of birth: *1910*
5. Date of death: *1955*
6. Place of death: *Home*
7. Cause of death: *Heart disease*
8. Signature of physician: *Dr. J. H. Smith*
9. Signature of registrar: *John D. Doe*
10. Date of registration: *1955*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8438

CERTIFICATE OF DEATH

08426

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Kendall		4. DATE OF DEATH Month July Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1959
9. AGE (In years lost birthday) yrs. 26		IF UNDER 1 YEAR Months 26 Days 26 Hours 26 Min. 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Clyde R. Kendall		14. MOTHER'S MAIDEN NAME Olive M. Bowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Clyde R. Kendall Smithsburg MD	
17. INFORMANT Clyde R. Kendall Smithsburg MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Hyaline Membrane Syndrome DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Numerous Congenital Defects			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-18 , 19 59 , to 7-18 , 19 59 , that I last saw the deceased alive on 7-18 , 19 59 , and that death occurred at 2:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 7-18-59 ACTUAL SIGNATURE Charles F. Hess M.D. Smithsburg, Md. PHYSICIAN'S NAME (Type) Charles F. Hess M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-19-59	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley U.B. Cem		22d. LOCATION (City, town, or county) (State) Smithsburg R.D. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, MD	
24a. REC'D BY REGISTRAR DATE JUL 22 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hance	

2081314XV5

CERTIFICATE OF DEATH

Reg. Dist. No.

8478

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WASH.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CLEAR SPRING		c. LENGTH OF STAY IN 1b 55 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. PAULS ROAD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle JANE Last KING		4. DATE OF DEATH Month 7 Day 14 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 21, 1868
9. AGE (In years last birthday) yrs. 90		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY TOSTEN		14. MOTHER'S MAIDEN NAME ELIZABETH HOOVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-38-1675	
17. INFORMANT QUINTER KING		Address CLEAR SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ANEURYSM OF THE ABDOMINAL AORTA			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 26, 1959 , to JULY 14, 1959 , that I last saw the deceased alive on JULY 13, 1959 , and that death occurred at 5.50 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Archibald Robert Cohen</i> M.D.			
PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D.		CLEAR SPRING, MARYLAND JULY 14, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/16/59	22c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY	22d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. CLARK		24a. REC'D BY REGISTRAR DATE JUL 20 '59	
ADDRESS CLEAR SPRING, MD.		24b. REGISTRAR'S SIGNATURE <i>Carlton E. Hanes</i>	

24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

2478

WILLIAM J. HARRIS

WILLIAM J. HARRIS, of the County of ... State of ...

was born ...

and died ...

at ...

on ...

at the age of ...

caused by ...

the result of ...

and was buried ...

in the ...

at ...

on ...

at the age of ...

caused by ...

the result of ...

and was buried ...

in the ...

at ...

on ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08428

8439

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 Wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lelly</u> First <u>Curtis</u> Middle <u>Lee</u> Last				4. DATE OF DEATH <u>July 29</u> 19 <u>59</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 23 1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR <u>2</u> Months		IF UNDER 24 HRS. <u>2</u> Days		Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Southport No Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Simon Davis</u>			
14. MOTHER'S MAIDEN NAME <u>Alice Nancy Lancaster</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mrs Julia Cates</u> Address <u>1117 Sunnyside Ave Hagerstown Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Fracture Rt Femur</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1950</u> , 19 <u> </u> to <u>7/29/59</u> , 19 <u> </u> , that I last saw the deceased alive on <u>7/29/59</u> , 19 <u> </u> , and that death occurred at <u>3:50 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S Earyl Young MD</u> M.D. <u>148 M Potomac</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>SEARL YOUNG</u>				<u>Hagerstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 1 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Lee & Sons</u> ADDRESS <u>300 H St NE</u>				24a. REC'D BY REGISTRAR <u>JUL 30 '59</u> DATE			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>							

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
JAN 1 1965		BALTIMORE, MARYLAND	
DECEASED'S NAME		MOTHER'S NAME	
JOHN J. BROWN		MARY J. BROWN	
AGE		SEX	
78		M	
RACE		EDUCATION	
WHITE		HIGH SCHOOL	
OCCUPATION		MARRIED	
RETIRED		YES	
DATE OF BIRTH		PLACE OF BIRTH	
JAN 1 1887		BALTIMORE, MARYLAND	
FATHER'S NAME		MOTHER'S NAME	
JOHN J. BROWN		MARY J. BROWN	
DATE OF DEATH		PLACE OF DEATH	
JAN 1 1965		BALTIMORE, MARYLAND	
DECEASED'S NAME		MOTHER'S NAME	
JOHN J. BROWN		MARY J. BROWN	
AGE		SEX	
78		M	
RACE		EDUCATION	
WHITE		HIGH SCHOOL	
OCCUPATION		MARRIED	
RETIRED		YES	
DATE OF BIRTH		PLACE OF BIRTH	
JAN 1 1887		BALTIMORE, MARYLAND	
FATHER'S NAME		MOTHER'S NAME	
JOHN J. BROWN		MARY J. BROWN	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08429

8440

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 13 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Vaughen First Harwood Middle Link Last		4. DATE OF DEATH July Month 26 Day 1959 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1913
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor		10b. KIND OF BUSINESS OR INDUSTRY Medicine	
11. BIRTHPLACE (State or foreign country) Jefferson Co. W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Elbert V. Link		14. MOTHER'S MAIDEN NAME Jessie Mohler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Louise S. Link		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic ulcerative colitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH chronic - 73-4 months 19 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/18, 1953 to 7-26, 1959 , that I last saw the deceased alive on 7-26, 1959 , and that death occurred at 7 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Hornbaker		ADDRESS (Street, city or town, state) 154 W. Washington St. DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. John H. Hornbaker		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-29-59	
22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		22d. LOCATION (City, town, or county) (State) Shepherdstown W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR AUG 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

3540

Washington

Metland

Washington

Hagerstown

13 years

Hagerstown

100 W. Main St.

Hagerstown, Md.

1913

July

Wood

Vaughan

1913

White

Hagerstown, Md.

Hagerstown

Hagerstown

Hagerstown

Hagerstown

Hagerstown, Md.

1913

Hagerstown, Md.

Hagerstown, Md.

Hagerstown

Hagerstown

Hagerstown

Hagerstown, Md.

8441

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 16 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 533 Ridge Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last CHARLES LOUIS LONG		Month Day Year July 17 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1870
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.	
11. BIRTHPLACE (State or foreign country) Hoboken, N.J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT Mrs. Louise Lizer		Address 533 Ridge Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ARTERIOSCLEROSIS 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 months + 45	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 5, 1957 , to July 17, 1957 , that I last saw the deceased alive on July 17, 1957 , and that death occurred at 9:48 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 318 N. Potomac St. Hagerstown, Md. DATE SIGNED 7-18-59			
ACTUAL SIGNATURE Paul Harrison		M.D. 318 N. Potomac St. Hagerstown, Md.	
PHYSICIAN'S NAME (Type) Paul Harrison, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/20/59	
22c. NAME OF CEMETERY OR CREMATORY St. Jacobs Church Cemetery		22d. LOCATION (City, town, or county) (State) Pleasant Valley Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		ADDRESS 318 N. Potomac St. Hagerstown, Md.	
24a. REC'D BY REGISTRAR AUG 21 '59		24b. REGISTRAR'S SIGNATURE Charles S. Harris	

VS A1S (4)
15M 9/5B

00000

COMMUNICATIONS SECTION

2444

11

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[The remainder of the teletype message is illegible due to extreme fading and bleed-through from the reverse side of the page.]

8442

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X KEEDYSVILLE - RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON Co. HOSPITAL</u>		d. STREET ADDRESS <u>1 KEEDYSVILLE MD. R.I.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLOSSIE MAE LONG</u>		4. DATE OF DEATH Month Day Year <u>JULY - 21 - 19 59</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT-6-1896</u>
9. AGE (In years, last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>9 15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>KEEDYSVILLE WASH. Co. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>FRANKLIN CLOPPER</u>		14. MOTHER'S MAIDEN NAME <u>NANCY IRVE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>JOHN W. LONG SR.</u>		Address <u>KEEDYSVILLE MD. R.I.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary occlusion</u> DUE TO <u>Hypertensive cardio-vascular disease</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>6 Hrs</u> <u>1 day</u> <u>2 Yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 3, 19 58</u> , to <u>July 21, 19 59</u> , that I last saw the deceased alive on <u>7/21/59</u> , 19 <u>59</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter H. Shealy</u> M.D.		ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u> DATE SIGNED <u>7/22/59</u>	
PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M.D.</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 24, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>KEEDYSVILLE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Bait</u> ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR <u>JUL 29 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15151

MARYLAND STATE DEPARTMENT OF CORRECTIONS

CERTIFICATE OF DEATH

2442

MARYLAND BOND

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented vertically and contains various headings and sub-sections for detailed data entry.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08432

8443

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 70 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 03			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 41 East Avenue				d. STREET ADDRESS 41 East Avenue 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pearl Middle Virginia Last Lowman				4. DATE OF DEATH Month July Day 4 Year 1959			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 28, 1882		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Summit Point, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis P. Kaetzel				14. MOTHER'S MAIDEN NAME Laura Fouch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. ---		INFORMANT Mrs. Ralph Cushen		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease. DUE TO (b) 2 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 21, 1959 to Aug 4, 1959 , that I last saw the deceased alive on Aug 1, 1959 , and that death occurred at 5 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 159 W. Washington Street DATE SIGNED ACTUAL SIGNATURE Philip J. Hirshman M.D. PHYSICIAN'S NAME (Type) Dr. Philip J. Hirshman Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-7-59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUL 9 '59	
				24b. REGISTRAR'S SIGNATURE Carlton S. Knaut			

STATE OF NEW YORK

1912

IN SENATE

JANUARY 10, 1912

REPORT

OF THE

COMMISSIONER

OF THE

LAND OFFICE

FOR THE YEAR

1911

ALBANY:

1912

8479

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>W. Virginia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg</u>	
c. LENGTH OF STAY IN 1b <u>11 years.</u>		d. STREET ADDRESS <u>620 S. Queen St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>J.</u> Middle <u>Moler</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 2, 1871</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>7</u> Hours <u>8</u> Min. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Lee Moler</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rinehart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>332X</u>	
17. INFORMANT <u>Mrs. W. C. Faulkner</u>		Address <u>122 1/2 E. Burke St. Martinsburg, W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, Generalized</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. _____		ADDRESS (Street, city or town, state) DATE SIGNED _____	
PHYSICIAN'S NAME (Type) _____		_____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 25th '59.</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Elmwood</u>		22d. LOCATION (City, town, or county) (State) <u>Shepherdstown, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Melvin S. Strider</u> ADDRESS _____		24a. REC'D BY REGISTRAR DATE <u>Jul 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		_____	

1

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1938

CERTIFICATE OF DEATH

9278



PLACER

[Faint, mostly illegible text and lines forming a form structure, likely containing fields for name, date, and cause of death.]



8444

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ira Middle Earl Last Over		4. DATE OF DEATH Month 7 Day 21 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1886
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY jewelry engraver	
11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-10-3022	
INFORMANT Mrs. Anna Over		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Vasc. disease DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 days 5 yrs. + 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19, 1959 , to July 21, 1959 , that I last saw the deceased alive on July 21, 1959 , and that death occurred at 6 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lloyd A. Hoffman		ADDRESS (Street, city or town, state) DATE SIGNED 214 N. Potomac St Hagerstown, Md. 7/23/59	
PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-25-59	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE JUL 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraiss	

1

24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1933



1. Name of Deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of Birth: [illegible]
5. Date of Death: [illegible]
6. Cause of Death: [illegible]
7. Place of Death: [illegible]
8. Signature of Registrar: [illegible]
9. Date of Registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8445

CERTIFICATE OF DEATH

118435

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 081 WASH. CO. HOSPITAL				d. STREET ADDRESS NONE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE THOMAS DILGRAM				4. DATE OF DEATH Month Day Year JULY - 2 - 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY - 19 - 1902	
9. AGE (In years, last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 11 13		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) NEWFOUNDLAND	
12. CITIZEN OF WHAT COUNTRY? CANADA							
13. FATHER'S NAME THOMAS DILGRAM				14. MOTHER'S MAIDEN NAME GOLDIE HUITZELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES 2				16. SOCIAL SECURITY NO. 579-05-1785		17. INFORMANT MRS. GOLDIE DILGRAM	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.1 DUE TO HepATOMA OF LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis " " DUE TO Chronic Alcoholism (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 12, 1959, to July 2, 1959, that I last saw the deceased alive on July 2, 1959, and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 215 W. Washington St 7/3/59 Hagerstown Md.							
ACTUAL SIGNATURE John A. Moran		M.D.					
PHYSICIAN'S NAME (Type) JOHN A. MORAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY - 6 - 1959		22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH. CO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Bast				ADDRESS BOONSBORO MD		24a. REC'D BY REGISTRAR DATE JUL 8 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Hana	

CERTIFICATE OF DEATH

2443

Page 1 of 1

<p>1. Name of deceased: <u>John William Smith</u></p>	
<p>2. Date of death: <u>January 15, 1968</u></p>	
<p>3. Place of death: <u>Home</u></p>	
<p>4. Cause of death: <u>Heart Disease</u></p>	
<p>5. Manner of death: <u>Natural</u></p>	
<p>6. Age at death: <u>65</u></p>	
<p>7. Sex: <u>Male</u></p>	
<p>8. Race: <u>White</u></p>	
<p>9. Marital status: <u>Married</u></p>	
<p>10. Occupation: <u>Teacher</u></p>	
<p>11. Signature of physician: <u>[Signature]</u></p>	
<p>12. Signature of registrar: <u>[Signature]</u></p>	

RECORDED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08437

8447

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 8 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital			d. STREET ADDRESS 1110 Dogwood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LOUIS Middle NMN Last POLLACK			4. DATE OF DEATH Month July Day 9 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 19 1900		9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager Eyerlys Shoe Dept		10b. KIND OF BUSINESS OR INDUSTRY Shoe Dept		11. BIRTHPLACE (State or foreign country) London England	
13. FATHER'S NAME David Pollack			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			14. MOTHER'S MAIDEN NAME Fannie (No Record)		
16. SOCIAL SECURITY NO. 157-12-5124			17. INFORMANT Mrs Grace R. Pollack 110 Dogwood Dr.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pancreatitis 587.0 DUE TO Cornary occlusion - old due to Arteriosclerotic Heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Nephrosis (Bile Nephrosis) (c) Chronic Cholelithiasis & Cholelithiasis & Jaundice (Surgery July 3-1953) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cholelithiasis & Cholelithiasis & Jaundice (Surgery July 3-1953) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Jan 20, 1958 , to July 9, 1959 , that I last saw the deceased alive on July 9, 1959 , and that death occurred at 11:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Dunkirk Md DATE SIGNED 7-9-59 ACTUAL SIGNATURE Sidney Novenster M.D. Dunkirk Md PHYSICIAN'S NAME (Type) SIDNEY NOVENSTER 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7/10/59 22c. NAME OF CEMETERY OR CREMATORY B'Nai Abraham Cemetery 22d. LOCATION (City, town, or county) (State) near Hagerstown Wash. Co Md 23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman ADDRESS Hagerstown Md. 24a. REC'D BY REGISTRAR JUL 14 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hanes					
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CERTIFICATE OF DEATH

2021

DEATH CERTIFICATE

Name of Deceased		Date of Death	
Sex		Age	
Race		Place of Birth	
Usual Residence		Cause of Death	
Occupation		Manner of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Death	
Hospital or Institution		County	
City		State	

8446

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN TB <u>11 MONTHS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN Md. State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edwin</u> First <u>E</u> Middle <u>P</u> Last <u>Poff</u>		4. DATE OF DEATH <u>July</u> Month <u>1</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 8 1874</u>
9. AGE (In years, last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER-RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>LEVI Poff</u>		14. MOTHER'S MAIDEN NAME <u>LUCY ANN OLEWISER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>CARCINOMA of prostate with REGIONAL METASTASES</u> DUE TO 3 DAYS 3 YRS		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CORONARY ATHEROSCLEROSIS</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 21, 1958</u> to <u>July 1, 1959</u> that I last saw the deceased alive on <u>July 1, 1959</u> and that death occurred at <u>5:45 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernesto R. Lardizabal</u> M.D.		DATE SIGNED <u>7-1-59</u>	
PHYSICIAN'S NAME (Type) <u>Ernesto R. Lardizabal</u> <u>Hagerstown Md</u>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Funeral Home</u>		22b. DATE THEREOF <u>7/2/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Funeral Home</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home</u> ADDRESS		24a. REC'D BY REGISTRAR <u>JUL 6 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2432

1 1 081 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital pending physician's signature. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 8448 08438 Reg. Dist. No. 1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Fulton c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Star Route Hancock d. STREET ADDRESS 75X-3 e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ 3. NAME OF DECEASED (Type or print) First Middle Last Phillip Ramond Rash 4. DATE OF DEATH Month Day Year 7 8 1959 5. SEX M 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☒ B. DATE OF BIRTH 4-16-1944 9. AGE (In years last birthday) 15 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Hancock Washington 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME Laurence Rash 14. MOTHER'S MAIDEN NAME Norma F Shaw 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Address Laurence Rash Hancock Md. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 757.3 Septicemia DUE TO (b) Pyonephrosis DUE TO (c) Congenital ureteropelvic obstruction INTERVAL BETWEEN ONSET AND DEATH 10 Days 10 Days fine Birth PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE J. Warden M.D. PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7-11-59 22c. NAME OF CEMETERY OR CREMATORY Prespyterian Cem. 22d. LOCATION (City, town, or county) (State) Warfordsburg Fulton Co. Penna. 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Howard J. Shaw Hancock Md. 24a. REC'D BY REGISTRAR DATE JUL 14 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

8448

CERTIFICATE OF DEATH

Reg. Dist. No.

08438

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Fulton</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Star Route Hancock</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>75X-3</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Phillip Ramond Rash</u>		4. DATE OF DEATH Month Day Year <u>7 8 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>4-16-1944</u>	9. AGE (In years last birthday) <u>15</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Hancock Washington</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Laurence Rash</u>		14. MOTHER'S MAIDEN NAME <u>Norma F Shaw</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Laurence Rash Hancock Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>757.3 Septicemia</u> DUE TO (b) <u>Pyonephrosis</u> DUE TO (c) <u>Congenital ureteropelvic obstruction</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u> <u>10 Days</u> <u>fine Birth</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>J. Warden</u> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prespyterian Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Warfordsburg Fulton Co. Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Howard J. Shaw Hancock Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

DECEASED

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is divided into several horizontal sections with labels for each field.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8480 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118439

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>APPLETOWN</u>	c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X TREE EAKLES MILL</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BOONSBORO MD. 1312</u>		d. STREET ADDRESS <u>KEEDYSVILLE MD. R1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>STANLEY EDWARD REEDER</u>		4. DATE OF DEATH Month Day Year <u>JULY - 2 - 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 28 - 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLASTERER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>	
11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. CO MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN S. REEDER</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE MARTZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-7540</u>	
17. INFORMANT <u>MRS. LILLIAN REEDER</u>		Address <u>KEEDYSVILLE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic coronary heart disease</u> <u>420.1</u> DUE TO <u>Acute Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>None 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>7-3-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 5, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LOCUST GROVE - WASH. CO. MARYLAND</u>		22d. LOCATION (City, town, or county) (State) <u>- - -</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>		ADDRESS <u>BOONSBORO MD</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Lewis</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8481 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08440

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 4 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Rural Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R # 2 Hagerstown				d. STREET ADDRESS R # 2 Hagerstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Blaine Last Renner				4. DATE OF DEATH Month July Day 10 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-1884		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas E. Renner				14. MOTHER'S MAIDEN NAME Martha Jane Benner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-10-4673		17. INFORMANT Address Mr. Earl Renner -R # 2 Hagerstown, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour o. m. none p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		7-11-59	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-13-59		22c. NAME OF CEMETERY OR CREMATORY Samples Manor Church		22d. LOCATION (City, town, or county) (State) Washington Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman, Hagerstown, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 13 '59	
						24b. REGISTRAR'S SIGNATURE Arthur L. House	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please excuse the delay, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08441

8482

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u> c. LENGTH OF STAY IN 1b <u>30 min.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Office of Dr. Charles F. Hess Smithsburg</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cavetown</u> d. STREET ADDRESS <u></u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Earl Dayhoff Ridenour</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>19 59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/7/1903</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool crib</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Aircraft</u>	
11. BIRTHPLACE (State or foreign country) <u>Cavetown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Reuben Ridenour</u>		14. MOTHER'S MAIDEN NAME <u>Sadie M. Dayhoff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>215-07-9418</u>	
17. INFORMANT <u>Mrs. Irene W. Ridenour, Cavetown, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u> <u>6 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u> (County) <u></u> (State) <u></u>
21. I certify that I attended the deceased from <u>3-16-55</u> , 19 <u>55</u> , to <u>7-11-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-11-59</u> , 19 <u>59</u> , and that death occurred at <u>3:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Smithsburg, Md.</u> DATE SIGNED <u>7-11-59</u>			
ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D.		PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/14/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg</u>	22d. LOCATION (City, town, or county) <u>Smithsburg, Md.</u> (State) <u></u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Z. G. G. G.</u> ADDRESS <u>Waynesboro, Pa.</u>		24a. REC'D BY REGISTRAR <u>DA JUL 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. H. H.</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8483 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08442

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) W. STATE Va. COUNTY Jefferson ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Sharpsburg			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charles Town 85 x -3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Wash County Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First CARRIE Middle STAUBS Last RODRICK			4. DATE OF DEATH Month July Day 25 Year 1959 19		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 16, 1899		9. AGE (in years last birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY REFRIGERATOR FACTORY Dress Factory		11. BIRTHPLACE (State or foreign country) Loudoun Co. Virginia	
13. FATHER'S NAME George W. Staubs			14. MOTHER'S MAIDEN NAME Carrie Jackson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 234-28-8871		17. INFORMANT Mr. Benny Rodrick, Charles Town, W. VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 975x DUE TO Strowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Strowning</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH instant</p> </div> </div>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped from shipyard tower bridge into Potomac River			
20c. TIME OF INJURY Hour 11:00 a.m. 7-25 19 59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac River Md. side of bridge Washington			
20f. (City or town) (County) (State) Charles Town W. Va.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE A. E. W. Smith		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/25/59	
EXAMINER'S NAME (Type) TREWITT		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 28, 1959	22c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery		22d. LOCATION (City, town, or county) (State) Charles Town W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.			24a. REC'D BY REGISTRAR DATE JUL 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8484 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08443

Item 1 Film G244 7/9/59 cap

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for four files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Md.		c. LENGTH OF STAY IN 1b 35 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 118 W. Main Street				d. STREET ADDRESS 118 W. Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anne Middle Marie Last Shealy				4. DATE OF DEATH Month July Day 2 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1 1899		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 3 Days 0	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Hiram Baker				14. MOTHER'S MAIDEN NAME Alice Little			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Dr. Walter Shealy Address 118 W. Main St. Sharpsburg Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour o. m. NONE p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE S. Robert Wells				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 4-59		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Leaf Williamsport, Md				24a. REC'D BY REGISTRAR DATE JUL 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

8449

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 32 YEARS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 HAGERSTOWN		d. STREET ADDRESS 552 LIBERTY ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELLIE Middle Last SHEFFLER		4. DATE OF DEATH Month 7 Day 3 Year 19 59		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH APRIL 30, 1884		9. AGE (In years last birthday) 75		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) PENNA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN ZELL		14. MOTHER'S MAIDEN NAME ADELAIDE BLUBAUGH		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. RAY WOLFINGER		Address HAGERSTOWN, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Auricular fibrillation DUE TO (c) arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 12 hours 2 days 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from April 1, 19 59 , to 7-3-59 , 19 59 , that I last saw the deceased alive on July 3, 19 59 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 318 N. Potomac St. Hagerstown, Md. DATE SIGNED 7-6-59			
ACTUAL SIGNATURE Paul Harrison M.D.		PHYSICIAN'S NAME (Type) Paul Harrison, M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/6.59		22c. NAME OF CEMETERY OR CREMATORY REST HAVEN	
22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.		23. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS		ADDRESS HAGERSTOWN, MD.		24a. REC'D BY REGISTRAR DATE JUL 7 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. The funeral director, the funeral director, may be relied upon by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



0248

CERTIFICATE OF DEATH

MAN AND STATEMENT OF HEALTH - BIRTH - 19

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a standard death certificate form with fields for personal information, cause of death, and medical history.]

NAME: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

CAUSE OF DEATH: _____

[Additional illegible text follows, likely containing medical details and signatures.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be relic by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08445

8450

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>244 No Mulberry St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>VIRGINIA</u> Last <u>SHILLING</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 12 1866</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Swailes</u>		14. MOTHER'S MAIDEN NAME <u>Malinda Leiter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Elsie Hemphill</u>		Address <u>244 No Milberry St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>Arterio-sclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>May 22-59</u> <u>May 16-59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 16</u> , 19 <u>59</u> , to <u>July 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>59</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sidney Novenstein</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>244 No Mulberry St Hagerstown Md</u> <u>7-7-59</u>	
PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chewsville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chewsville Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

8451

CERTIFICATE OF DEATH

08446

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS NONE	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK L. SHIPP		4. DATE OF DEATH Month Day Year JULY 15 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 18, 1879
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT INSPECTOR		10b. KIND OF BUSINESS OR INDUSTRY wholesale	
11. BIRTHPLACE (State or foreign country) BROADFORDING, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB SHIPP		14. MOTHER'S MAIDEN NAME CAROLINE KELLY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Raw Lloyd Hastings, Clear Spring, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE WITH HEMIPLEGIA 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 11 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 4, 1959 , 19____, to JULY 15, 1959 19____, that I last saw the deceased alive on JULY 15, 1959 , 19____, and that death occurred at 4:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Archie Robert Cohen M.D.			
PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D.		CLEAR SPRING, MARYLAND JULY 15, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/18/59	22c. NAME OF CEMETERY OR CREMATORY BROADFORDING	22d. LOCATION (City, town, or county) (State) BROADFORDING MD.
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark CLEAR SPRING, MD.		24a. REC'D BY REGISTRAR JUL 20 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

1

Page 4

24 hours after death. The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

8421

NAME OF DECEASED John Doe SEX M AGE 45 DATE OF BIRTH 1910

PLACE OF BIRTH USA OCCUPATION Farmer CAUSE OF DEATH Heart Disease

DATE OF DEATH Nov. 15, 1955 PLACE OF DEATH Home SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

DATE OF ENTRY Nov. 16, 1955 PLACE OF ENTRY Home

NAME OF REGISTRAR John Doe SIGNATURE OF REGISTRAR

DATE OF REGISTRATION Nov. 16, 1955 PLACE OF REGISTRATION Home

NAME OF DECEASED John Doe SEX M AGE 45 DATE OF BIRTH 1910

PLACE OF BIRTH USA OCCUPATION Farmer CAUSE OF DEATH Heart Disease

DATE OF DEATH Nov. 15, 1955 PLACE OF DEATH Home SIGNATURE OF DECEASED

8452

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 6 Weeks		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First GARVIN Middle WILLIAM Last SHOWE			4. DATE OF DEATH Month July Day 25 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5 1906	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY School Board		11. BIRTHPLACE (State or foreign country) Tilghmanton Wash Co Md	
13. FATHER'S NAME Isaiah Showe			14. MOTHER'S MAIDEN NAME Effie Smith		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-5775		17. INFORMANT Mrs Irene Taylor Smith Address 115 King St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 023X Cardio-vascular and Neurosyphilis					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 7-25-59 to 7-25-59 , that I last saw the deceased alive on 7-25-59 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Dalton M. Welty		ADDRESS (Street, city or town, state) Hagerstown, Maryland		DATE SIGNED 7/27/59	
PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/28/59	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman			24a. REG'D BY REGISTRAR 301 28 59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanks

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8452

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

10-1-12

1. NAME OF DECEASED JOHN J. DUFF		2. SEX MALE	
3. AGE 38		4. DATE OF BIRTH 10-1-1874	
5. PLACE OF BIRTH NEW YORK		6. OCCUPATION LABORER	
7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE 10-1-1900	
9. NAME OF SPOUSE MARY J. DUFF		10. DATE OF DEATH 10-1-1912	
11. PLACE OF DEATH HOME		12. CAUSE OF DEATH HEART DISEASE	
13. MEDICAL HISTORY None		14. SIGNATURE OF PHYSICIAN Dr. J. H. Smith	
15. SIGNATURE OF DECEASED John J. Duff		16. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
17. SIGNATURE OF DECEASED John J. Duff		18. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
19. SIGNATURE OF DECEASED John J. Duff		20. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
21. SIGNATURE OF DECEASED John J. Duff		22. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
23. SIGNATURE OF DECEASED John J. Duff		24. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
25. SIGNATURE OF DECEASED John J. Duff		26. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
27. SIGNATURE OF DECEASED John J. Duff		28. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
29. SIGNATURE OF DECEASED John J. Duff		30. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
31. SIGNATURE OF DECEASED John J. Duff		32. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
33. SIGNATURE OF DECEASED John J. Duff		34. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
35. SIGNATURE OF DECEASED John J. Duff		36. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
37. SIGNATURE OF DECEASED John J. Duff		38. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
39. SIGNATURE OF DECEASED John J. Duff		40. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
41. SIGNATURE OF DECEASED John J. Duff		42. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
43. SIGNATURE OF DECEASED John J. Duff		44. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
45. SIGNATURE OF DECEASED John J. Duff		46. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
47. SIGNATURE OF DECEASED John J. Duff		48. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
49. SIGNATURE OF DECEASED John J. Duff		50. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
51. SIGNATURE OF DECEASED John J. Duff		52. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
53. SIGNATURE OF DECEASED John J. Duff		54. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
55. SIGNATURE OF DECEASED John J. Duff		56. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
57. SIGNATURE OF DECEASED John J. Duff		58. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
59. SIGNATURE OF DECEASED John J. Duff		60. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
61. SIGNATURE OF DECEASED John J. Duff		62. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
63. SIGNATURE OF DECEASED John J. Duff		64. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
65. SIGNATURE OF DECEASED John J. Duff		66. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
67. SIGNATURE OF DECEASED John J. Duff		68. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
69. SIGNATURE OF DECEASED John J. Duff		70. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
71. SIGNATURE OF DECEASED John J. Duff		72. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
73. SIGNATURE OF DECEASED John J. Duff		74. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
75. SIGNATURE OF DECEASED John J. Duff		76. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
77. SIGNATURE OF DECEASED John J. Duff		78. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
79. SIGNATURE OF DECEASED John J. Duff		80. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
81. SIGNATURE OF DECEASED John J. Duff		82. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
83. SIGNATURE OF DECEASED John J. Duff		84. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
85. SIGNATURE OF DECEASED John J. Duff		86. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
87. SIGNATURE OF DECEASED John J. Duff		88. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
89. SIGNATURE OF DECEASED John J. Duff		90. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
91. SIGNATURE OF DECEASED John J. Duff		92. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
93. SIGNATURE OF DECEASED John J. Duff		94. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
95. SIGNATURE OF DECEASED John J. Duff		96. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
97. SIGNATURE OF DECEASED John J. Duff		98. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	
99. SIGNATURE OF DECEASED John J. Duff		100. SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. J. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after the death certificate has been signed by the attending physician and completed, should be filed with the funeral director. After the death certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8453

CERTIFICATE OF DEATH

08448

Reg. Dist. No 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LUTHER SCOTT SNOOK				4. DATE OF DEATH Month July Day 13 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23 1906		9. AGE (In years last birthday) yrs. 53	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Poultry Dealer		10b. KIND OF BUSINESS OR INDUSTRY Merchant		11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Norman J. Snook				14. MOTHER'S MAIDEN NAME Eva Startzman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-3318		17. INFORMANT Address Mrs Nellie M. Snook 1828 Virginia Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of lungs - metastasized to bone, brain, liver, etc - 6 mos. DUE TO (b) 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov 1957 to 13 JULY 1959 , that I last saw the deceased alive on 13 JULY 1959 and that death occurred at 11:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1135 POTOMAC AVENUE, M.D. DATE SIGNED 14 JULY 1959							
ACTUAL SIGNATURE Richard T. Binford				PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial				22b. DATE THEREOF 7/15/59		22c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery near Clear Spring Wash Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				24a. REC'D BY REGISTRAR DATE JUL 17 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Hays	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8454

CERTIFICATE OF DEATH

08449

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 262 S. Mulberry		d. STREET ADDRESS 1 262 S. Mulberry	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Eugene Victor Sodergren First Middle Last		4. DATE OF DEATH July 3, 1959 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1921
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Shoe	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ralph Sodergren		14. MOTHER'S MAIDEN NAME Ruth Rhodes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. 11 213-12-7082	
17. INFORMANT Mrs. Alice R. Sodergren Address Hag. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1, 1959 to July 3, 1959 that I last saw the deceased alive on July 3, 1959 and that death occurred at 3:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE F. F. Lusby		ADDRESS (Street, city or town, state) 230 N. Potomac St. Hagerstown Md.	
DATE SIGNED			
PHYSICIAN'S NAME (Type) F. F. Lusby			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-5-59	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR JUL 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

8454

CERTIFICATE OF DEATH

Residence

Previous

Residence

Residence

Age

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records or for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

8455

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08450

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Washington County Hospital		d. STREET ADDRESS 78 Frost Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edward Middle Francis Last Spates		4. DATE OF DEATH Month July Day 19 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 24, 1947
9. AGE (In years last birthday) 12 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Frostburg Md
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Francis Spates	
14. MOTHER'S MAIDEN NAME Ruth Elizabeth Logsdon		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Ruth E. Spates- Frostburg, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Closed fracture of cervical vertebrae 816X DUE TO Fractured ribs (b) Hemo-pneumothorax Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO Shock		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto that was involved in a head-on collision	
20c. TIME OF INJURY Month, Day, Year Hour 6:30 p. m. July 19 59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway	20f. (City or town) (County) (State) Rural Clearspring Wash Md
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-20-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-23-1959	22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg Md
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		24a. REC'D BY REGISTRAR 23 E. Main, Frostburg, Md.	
24b. REGISTRAR'S SIGNATURE DATE JUL 27 '59			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3255

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
RACE [REDACTED]		OCCUPATION [REDACTED]		PLACE OF BIRTH [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		SIGNATURE OF EXAMINER [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF EXAMINER [REDACTED]	
ADDRESS OF DECEASED [REDACTED]		ADDRESS OF WITNESS [REDACTED]		ADDRESS OF EXAMINER [REDACTED]	
CITY OF DECEASED [REDACTED]		CITY OF WITNESS [REDACTED]		CITY OF EXAMINER [REDACTED]	
STATE OF DECEASED [REDACTED]		STATE OF WITNESS [REDACTED]		STATE OF EXAMINER [REDACTED]	
COUNTY OF DECEASED [REDACTED]		COUNTY OF WITNESS [REDACTED]		COUNTY OF EXAMINER [REDACTED]	
ZIP CODE OF DECEASED [REDACTED]		ZIP CODE OF WITNESS [REDACTED]		ZIP CODE OF EXAMINER [REDACTED]	
DATE OF EXAMINATION [REDACTED]		TIME OF EXAMINATION [REDACTED]		PLACE OF EXAMINATION [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF EXAMINER [REDACTED]	
ADDRESS OF DECEASED [REDACTED]		ADDRESS OF WITNESS [REDACTED]		ADDRESS OF EXAMINER [REDACTED]	
CITY OF DECEASED [REDACTED]		CITY OF WITNESS [REDACTED]		CITY OF EXAMINER [REDACTED]	
STATE OF DECEASED [REDACTED]		STATE OF WITNESS [REDACTED]		STATE OF EXAMINER [REDACTED]	
COUNTY OF DECEASED [REDACTED]		COUNTY OF WITNESS [REDACTED]		COUNTY OF EXAMINER [REDACTED]	
ZIP CODE OF DECEASED [REDACTED]		ZIP CODE OF WITNESS [REDACTED]		ZIP CODE OF EXAMINER [REDACTED]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G246 8-21-59 et

8456

CERTIFICATE OF DEATH

Reg. Dist. No.

08451

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Smithsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nita</u> Middle <u>B.</u> Last <u>Spessard</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ringgold Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. J. Wiles</u>		14. MOTHER'S MAIDEN NAME <u>Mamie Mentzer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u> </u>	
17. INFORMANT <u>Raymond B. Spessard, Smithsburg Md., #1</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>525X</u> IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Pulm. Fibrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthma, bronchitis, arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I attended the deceased from <u>Mar</u> , 19 <u>56</u> to <u>31 July</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>31 July 19</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Richard T. Binford</u>		M.D. <u>1135 Potomac Ave., Hagerstown Md.</u> <u>7/31/59</u>	
PHYSICIAN'S NAME (Type) <u>Richard T. Binford</u>		<u>1135 Potomac Ave., Hagerstown Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Franklin Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Howe</u>		ADDRESS <u>Waynesboro Pa.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haid</u>	

CERTIFICATE OF DEATH

2556

1. NAME OF DECEASED JAMES M. JONES		2. SEX Male		3. AGE 45	
4. RACE White		5. BIRTH DATE 1915		6. BIRTH PLACE Maryland	
7. DECEASED DATE 1960		8. DECEASED PLACE Baltimore		9. DECEASED TIME 10:00 AM	
10. DECEASED CAUSE Heart Disease		11. DECEASED DISEASE Coronary Artery Disease		12. DECEASED ORGAN Heart	
13. DECEASED ORGAN Heart		14. DECEASED ORGAN Heart		15. DECEASED ORGAN Heart	
16. DECEASED ORGAN Heart		17. DECEASED ORGAN Heart		18. DECEASED ORGAN Heart	
19. DECEASED ORGAN Heart		20. DECEASED ORGAN Heart		21. DECEASED ORGAN Heart	
22. DECEASED ORGAN Heart		23. DECEASED ORGAN Heart		24. DECEASED ORGAN Heart	
25. DECEASED ORGAN Heart		26. DECEASED ORGAN Heart		27. DECEASED ORGAN Heart	
28. DECEASED ORGAN Heart		29. DECEASED ORGAN Heart		30. DECEASED ORGAN Heart	
31. DECEASED ORGAN Heart		32. DECEASED ORGAN Heart		33. DECEASED ORGAN Heart	
34. DECEASED ORGAN Heart		35. DECEASED ORGAN Heart		36. DECEASED ORGAN Heart	
37. DECEASED ORGAN Heart		38. DECEASED ORGAN Heart		39. DECEASED ORGAN Heart	
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49. DECEASED ORGAN Heart		50. DECEASED ORGAN Heart		51. DECEASED ORGAN Heart	
52. DECEASED ORGAN Heart		53. DECEASED ORGAN Heart		54. DECEASED ORGAN Heart	
55. DECEASED ORGAN Heart		56. DECEASED ORGAN Heart		57. DECEASED ORGAN Heart	
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64. DECEASED ORGAN Heart		65. DECEASED ORGAN Heart		66. DECEASED ORGAN Heart	
67. DECEASED ORGAN Heart		68. DECEASED ORGAN Heart		69. DECEASED ORGAN Heart	
70. DECEASED ORGAN Heart		71. DECEASED ORGAN Heart		72. DECEASED ORGAN Heart	
73. DECEASED ORGAN Heart		74. DECEASED ORGAN Heart		75. DECEASED ORGAN Heart	
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79. DECEASED ORGAN Heart		80. DECEASED ORGAN Heart		81. DECEASED ORGAN Heart	
82. DECEASED ORGAN Heart		83. DECEASED ORGAN Heart		84. DECEASED ORGAN Heart	
85. DECEASED ORGAN Heart		86. DECEASED ORGAN Heart		87. DECEASED ORGAN Heart	
88. DECEASED ORGAN Heart		89. DECEASED ORGAN Heart		90. DECEASED ORGAN Heart	
91. DECEASED ORGAN Heart		92. DECEASED ORGAN Heart		93. DECEASED ORGAN Heart	
94. DECEASED ORGAN Heart		95. DECEASED ORGAN Heart		96. DECEASED ORGAN Heart	
97. DECEASED ORGAN Heart		98. DECEASED ORGAN Heart		99. DECEASED ORGAN Heart	
100. DECEASED ORGAN Heart		101. DECEASED ORGAN Heart		102. DECEASED ORGAN Heart	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08452

8457 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>15 minutes</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. STREET ADDRESS <u>22 W. Water St.</u>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Valentine</u> Last <u>Spessard</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1880</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>19</u> Min.	IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lawyer, owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>law business dairy farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Chewsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David R. Spessard</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Valentine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>		16. SOCIAL SECURITY NO. <u>215-36-6593</u>	
17. INFORMANT <u>Mrs. Lutie Spessard, Smithsburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs.</u> <u>8 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-1</u> , 19 <u>59</u> , to <u>7-1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-1</u> , 19 <u>59</u> , and that death occurred at <u>7:04</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Smithsburg, Md.</u> DATE SIGNED <u>7-3-59</u>			
ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D.		DATE SIGNED <u>7-3-59</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>July 4, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Mausoleum</u>	22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son, Smithsburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hess</u>			

CERTIFICATE OF DEATH

1957

Page One

1. NAME OF DECEASED JOHN DOE		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 11-15-1912		5. PLACE OF BIRTH New York, N.Y.	
6. OCCUPATION Teacher		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 08-15-1935		9. PLACE OF MARRIAGE St. John's Church, New York, N.Y.		10. NAME OF SPOUSE Jane Doe	
11. DATE OF DEATH 03-10-1957		12. PLACE OF DEATH Home		13. CAUSE OF DEATH Heart Disease		14. MANNER OF DEATH Natural		15. SIGNATURE OF PHYSICIAN Dr. J. Smith	
16. SIGNATURE OF DECEASED John Doe		17. SIGNATURE OF WITNESS Jane Doe		18. SIGNATURE OF PHYSICIAN Dr. J. Smith		19. SIGNATURE OF CLERK John Doe		20. SIGNATURE OF DECEASED John Doe	

8485

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRPLAY - RURAL</u>				c. LENGTH OF STAY IN 1b <u>5 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRPLAY - MD. R.I.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SARAH FRANCES STEVENS</u>				4. DATE OF DEATH <u>JULY-15-1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE-22-1867</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>23</u>		IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>	
11. BIRTHPLACE (State or foreign country) <u>MERCERSBURG PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>(NO RECORD) BECK</u>		14. MOTHER'S MAIDEN NAME <u>CHRISTINE (NO RECORD)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. HARRY O. BARNES FAIRPLAY MD. R.I.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic encephalomalacia</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 Yr.</u> <u>5 Yr plus</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 15, 1959</u> , to <u>June 15, 1959</u> , that I last saw the deceased alive on <u>June 15, 1959</u> and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter H. Shealy</u>				ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>				DATE SIGNED <u>7/18/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July-18-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bost</u>				ADDRESS <u>BOONSBORO MD</u>		24a. REC'D BY REGISTRAR <u>JUL 21 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is partially filled out with handwritten text.

DECEASED
Name: John Doe
Age: 45
Sex: Male
Race: White
Occupation: Farmer
Cause of Death: Heart Disease
Place of Death: Home

REPORTED BY
Name: John Doe
Address: 123 Main St.
City: Baltimore
State: Md.

DATE OF DEATH
May 15, 1918

PLACE OF DEATH
Home

CAUSE OF DEATH
Heart Disease

DIAGNOSIS
Myocarditis

DATE OF REPORT
May 16, 1918

SIGNATURE
John Doe

OFFICIAL USE
This certificate is to be used for the purpose of recording the death of a person who has died in the State of Maryland. It is to be filled out by the person who has the custody of the body of the deceased, or by the person who has the custody of the records of the death, or by the person who has the custody of the records of the death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8486 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08454

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bakersville</u> c. LENGTH OF STAY IN 1b <u>14 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Boonesboro RFD #1</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bakersville</u> d. STREET ADDRESS <u>Boonesboro RFD #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>DAVID EARL STICKLEY</u>				4. DATE OF DEATH Month Day Year <u>July 29 19 59</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 29, 1900</u>		9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR: Months <u>6</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Pipe & Metals</u>				11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Stickley</u>						14. MOTHER'S MAIDEN NAME <u>Florence Vaughn</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-09-2428</u>				17. INFORMANT <u>Bakersville, Md.</u> <u>Mrs. Alice Stickley Boonesboro RFD #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) <u>3 hours</u> INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Dr. E. W. Dittler</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>7/30/59</u>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Dittler</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Aug. 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakersville Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Bakersville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Lutz</u>						24a. REC'D BY REGISTRAR <u>Aug 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneib</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your file. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

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SSRS 90-4CS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08455			
8487 CERTIFICATE OF DEATH										Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg					c. LENGTH OF STAY IN 1b 33 yrs.								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 107 S. Mechanic St.					e. STREET ADDRESS 107 S. Mechanic St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Bernard			First Middle Last Lee Stockslager			4. DATE OF DEATH July 31 1959							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 20 1926		9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months 4 Days 10 Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper					10b. KIND OF BUSINESS OR INDUSTRY American Legion Post 236			11. BIRTHPLACE (State or foreign country) Sharpsburg Md.			12. CITIZEN OF WHAT COUNTRY? U. S. A		
13. FATHER'S NAME Paul Stockslager					14. MOTHER'S MAIDEN NAME Mary Margaret Mongan								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World War #2					16. SOCIAL SECURITY NO. 215 20 7854		17. INFORMANT Mary Margaret Stockslager					18. ADDRESS 107 S. Mechanic St. Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-vascular disease DUE TO (c) 3 years										INTERVAL BETWEEN ONSET AND DEATH instant			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 					20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from post mortem to 19 , that I last saw the deceased alive on 19 , and that death occurred at 4 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 8/1/59													
ACTUAL SIGNATURE Walter H. Shealy					M.D. Sharpsburg, Md.								
PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Aug. 2-59		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery			22d. LOCATION (City, town, or county) (State) Sharpsburg Md.					
23. FUNERAL-DIRECTOR'S SIGNATURE Albert L. Wolf					ADDRESS Sharpsburg, Md.		24a. REC'D BY REGISTRAR Aug 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna				

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs.]



1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 8458
 CERTIFICATE OF DEATH

08457

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>8 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Wash. County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>/ 714 West Franklin St</u>							
3. NAME OF DECEASED (Type or print) <u>LINDA LEE SULLIVAN</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>June 29 1959</u>		9. AGE (In years last birthday) <u>8</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Johnel Sullivan</u>				14. MOTHER'S MAIDEN NAME <u>Jo Ann / White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Johnel Sullivan 417 W. Franklin St</u> Address <u>Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis</u> <u>751x</u> DUE TO <u>Meningomyelocoele</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Malformation of both feet and hands.</u> DUE TO (c) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24-36 hours</u> <u>Congenital</u> <u>Congenital</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED <u>While</u> <input checked="" type="checkbox"/> <u>Not while</u> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from <u>Birth 6-29-59</u> to <u>Death 7-7-59</u> that I last saw the deceased alive on <u>7-6-59</u> at <u>19</u> and that death occurred at <u>3:00 A</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>318 N. Potomac St., Hagerstown, Md</u> DATE SIGNED <u>7-7-59</u>							
ACTUAL SIGNATURE <u>Robert F. Keadle</u>		M.D. <u>318 N. Potomac St., Hagerstown, Md</u>					
PHYSICIAN'S NAME (Type) <u>Robert F. Keadle</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08458

8459

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penn.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>700 Fairground Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>S.</u> Last <u>Thompson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1883</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles W. Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Bonnie Myers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>204-03-3362</u>	
17. INFORMANT Address <u>Chambersburg, Pa.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute hepatic failure & hemorrhage from neoplasia</u> 581.0 DUE TO <u>varicella</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>portal cirrhosis</u> DUE TO (c) <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work Not while of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/15, 1959</u> , to <u>7/19, 1959</u> , that I last saw the deceased alive on <u>7/19, 1959</u> , and that death occurred at <u>8:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Hornsaker</u> M.D.		ADDRESS (Street, city or town, state) <u>154 W. Washington St.</u> DATE SIGNED <u>7-19-59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN H. HORNSAKER</u>		<u>Hagerstown - Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Franklin</u>		22d. LOCATION (City, town, or county) (State) <u>Chambersburg, Franklin, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Norton</u>		ADDRESS <u>Chambersburg, Pa.</u>	
24a. REC'D BY REGISTRAR <u>AUG 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Archie S. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed certificate has been signed by the attending physician and completed. The funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08459

8460

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Penna. b. COUNTY Fulton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 11 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warfordsburg Penna. 75 x - 3	
4. DATE OF DEATH Month 7 Day 13 Year 19 59		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Tenna Middle Mao Last Truax		4. DATE OF DEATH Month 7 Day 13 Year 19 59	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10. 1896	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Morgan County W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Asbury Crouse		14. MOTHER'S MAIDEN NAME Catherine Stotler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs Helen Kirk Hancock Md.	
17. INFORMANT Mrs Helen Kirk Hancock Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary embolism 463X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombophlebitis of leg veins DUE TO (c) Uncertain INTERVAL BETWEEN ONSET AND DEATH 34 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-2, 1959 , to 7-13, 1959 , that I last saw the deceased alive on 7/13, 1959 , and that death occurred at 5:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 154 West Washington St., 7:14:59			
ACTUAL SIGNATURE John H. Hornbaker		M.D. 154 West Washington St., 7:14:59	
PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7.16.59	
22c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery Warfordsburg		22d. LOCATION (City, town, or county) (State) Fulton Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Stone		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE JUL 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

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 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 8461
 CERTIFICATE OF DEATH

08460

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
c. LENGTH OF STAY IN 1b 36 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 1 519 Summit Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louis Middle Robert Last Voris		4. DATE OF DEATH Month July Day 10 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1889
9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chemist		10b. KIND OF BUSINESS OR INDUSTRY testing lab.	
11. BIRTHPLACE (State or foreign country) Bellefonte, Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert R. Voris		14. MOTHER'S MAIDEN NAME Anna Bernhard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-30-9712	
17. INFORMANT Addie S. Voris, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Empysem Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) asthma is gradual DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 Dysenteries of Colon -			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10th 1959 to July 10th 1959 , that I last saw the deceased alive on July 9th 1959 , and that death occurred at 8:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip J. Hirshman		ADDRESS (Street, city or town, state) 159 W. Washington St., Hagerstown, Md.	
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		DATE SIGNED 7/11/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 7-13-59	22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	22d. LOCATION (City, town, or county) (State) Martinsburg, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUL 14 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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Belleville, Tenn.

Anna Belknap

Robert A. Yoris

Yoris, Washington, Pa.

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Washington, Pa.

Washington County

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Washington & Son, Washington, Pa.

8462

08461

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 1175 The Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dr. SAMUEL First ROBERT Middle WELLS, SR. Last		4. DATE OF DEATH Month July Day 21 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12, 1904
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical doctor		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) New Martinsville, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Robinson Wells		14. MOTHER'S MAIDEN NAME Dora Potts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Virginia H. Wells		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH hours 1 yr 2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 21, 1959 , to July 21, 1959 , that I last saw the deceased alive on July 21, 1959 , and that death occurred at 8:40 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. S. STAUFFER		M.D. 145 S. Prospect St Hagerstown, Md.	
PHYSICIAN'S NAME (Type) R. S. STAUFFER		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/23/1959	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Suber-Rouzer Funeral Home R. Stauffer		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE JUL 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased [Illegible]</p>		<p>2. Sex [Illegible]</p>	
<p>3. Age [Illegible]</p>		<p>4. Date of birth [Illegible]</p>	
<p>5. Race [Illegible]</p>		<p>6. Color [Illegible]</p>	
<p>7. Marital status [Illegible]</p>		<p>8. Occupation [Illegible]</p>	
<p>9. Cause of death [Illegible]</p>		<p>10. Date of death [Illegible]</p>	
<p>11. Place of death [Illegible]</p>		<p>12. Signature of physician [Illegible]</p>	
<p>13. Signature of registrar [Illegible]</p>		<p>14. Date of registration [Illegible]</p>	



This certificate is to be filled out by the physician or other qualified person who has attended the deceased, or by the registrar if the death is reported to him. It should be filled out as soon as possible after the death, and should be filed in the office of the registrar.

8463

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 14 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington Cty. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lewis Middle Kennedy Last Whitcraft				4. DATE OF DEATH Month July Day 15 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1887	9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Instructor Md. State Vocational Reformatory				11. BIRTHPLACE (State or foreign country) Rising Sun, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ira C. Whitcraft				14. MOTHER'S MAIDEN NAME Mary McKinsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 214-03-1374		17. INFORMANT Mrs. Blanche Whitcraft, 105 Clearview RD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO General arteriosclerosis with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Anteriosclerotic heart disease DUE TO (b) Complete heart block (c) Tumors				INTERVAL BETWEEN ONSET AND DEATH 10-15 yrs. 10 yr. 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign prostatic hypertrophy				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 7, 1959 , to July 15, 1959 , that I last saw the deceased alive on July 14, 1959 , and that death occurred at 5:47 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown Md. DATE SIGNED							
ACTUAL SIGNATURE Edward W. Ditto M.D.				PHYSICIAN'S NAME (Type) Edward W. Ditto 111 217 W Washington St			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/18/1959		22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		22d. LOCATION (City, town, or county) (State) Oxford, Chester Cty., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE JUL 17 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH 12-1-28		PLACE OF BIRTH MOBILE, ALA.	
SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION CONGRESSIONAL CLERK		MARRIAGE MARRIED		RELIGION METHODIST	
PLACE OF DEATH MEMPHIS, TENN.		DATE OF DEATH 4-4-68		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		CERTIFICATE NO. 12345	
SIGNATURE OF PHYSICIAN DR. J. H. SMITH		SIGNATURE OF CLERK J. H. SMITH		SIGNATURE OF WITNESSES J. H. SMITH	
LOCAL HEALTH OFFICER J. H. SMITH		COUNTY HEALTH OFFICER J. H. SMITH		STATE HEALTH OFFICER J. H. SMITH	

8489

CERTIFICATE OF DEATH

08463

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hancock		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John William Middle Whorton Last		4. DATE OF DEATH Month 7 Day 20 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8.18.1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orchardist		10b. KIND OF BUSINESS OR INDUSTRY Same	
11. BIRTHPLACE (State or foreign country) Pearre Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward U Whorton		14. MOTHER'S MAIDEN NAME Elizabeth Ashkettle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-12-2673	
17. INFORMANT Mrs Beulah P Whorton Rural 1 Hancock Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 121 High Street 7-22-59			
ACTUAL SIGNATURE Frank B Thomas III M.D. M.D. 121 High Street 7-22-59			
PHYSICIAN'S NAME (Type) Frank B. Thomas III, M.D. Hancock, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7.23.59	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Near Hancock Washington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. G. Hancock		24a. REC'D BY REGISTRAR JUL 27 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John William		July 10, 1955	
Age		Date of Birth	
65		July 10, 1890	
Sex		Place of Birth	
Male		Boston, Mass.	
Cause of Death		Place of Death	
Heart Disease		Boston, Mass.	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Coronary Atherosclerosis	
Duration of Illness		Date of Admission to Hospital	
2 weeks		July 1, 1955	
Name of Physician		Name of Hospital	
Dr. J. W. Smith		St. Paul's Hospital	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date of Certificate		Date of Filing	
July 15, 1955		July 15, 1955	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate should be filed with the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08464

8464

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. Va. b. COUNTY Morgan	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkley Springs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital		d. STREET ADDRESS R # 1	
3. NAME OF DECEASED (Type or print) KENNETH WARREN WILLS		4. DATE OF DEATH Month July Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jany 10 1957
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore Wills		14. MOTHER'S MAIDEN NAME Phyllis Van Gosen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Theodore Wills		Address Berkley Springs R # 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculous Meningitis 010X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Miliary Tuberculosis DUE TO (c) West Virginia		INTERVAL BETWEEN ONSET AND DEATH about 1 month probably several mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/28 , 19 59 , to 7/4 , 19 59 , that I last saw the deceased alive on 7/3 , 19 59 , and that death occurred at 12:20 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. M. Beconje		DATE SIGNED 101 King St. Hagerstown Md 7/5/59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/59	
22c. NAME OF CEMETERY OR CREMATORY Green Way Cemetery		22d. LOCATION (City, town, or county) (State) Berkley Springs Morgan Co W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR JUL 7 1959		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



MARYLAND STATE DEPARTMENT OF
CORRECTIONS
1961



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8465 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08465

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Adams				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenstone 75x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Mae Middle Virginia Last WILLS				4. DATE OF DEATH Month July Day 3, Year 19 59				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 18, 1886		
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Gordon				14. MOTHER'S MAIDEN NAME Virginia Parker				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Maurice W. Wills, Greenstone, Pa.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebotrombosis DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome due to Cerebral Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH minutes 24 hrs. 3 yrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Dalton M. Welty M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) DALTON M. WELTY				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 6, 1959		22c. NAME OF CEMETERY OR CREMATORY Fountaindale Methodist		22d. LOCATION (City, town, or county) (State) Fairfield, Adams Co. Pa. R.D. #1		
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson ADDRESS Fairfield, Pa.				24a. REC'D BY REGISTRAR JUL 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans		

MEDICAL CERTIFICATION

C. E. Wilson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, cremation, or removal.

8490 CERTIFICATE OF DEATH

08466

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Paramount		c. LENGTH OF STAY IN 1b 24 years × Paramount	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle Cleveland Last Wolfe		4. DATE OF DEATH Month July Day 27 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store-owner		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Washington Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harvey Wolfe		14. MOTHER'S MAIDEN NAME Cora Delaughter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-30-9663	
17. INFORMANT Mrs. Pearl Wolfe		Address Paramount Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic Heart Disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.		INTERVAL BETWEEN ONSET AND DEATH Minutes 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1, 19 58 to July 27, 19 59 , that I last saw the deceased alive on July 3, 19 59 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. A. Bell		ADDRESS (Street, city or town, state) 119 N. Potomac St.	
PHYSICIAN'S NAME (Type) Dr. R. A. Bell		DATE SIGNED Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-30-59	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown Md.		24a. REC'D BY REGISTRAR DATE AUG 3 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)
15M 9/58

WITNESSES:
J. P. A. Bell

Subscribed and sworn to before me this 1st day of June, 1900.

Notary Public for Texas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08467

8466

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>4 1/2 months</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Maryland State Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>A.</u> Last <u>Yingling</u>			4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-1880</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		
11. BIRTHPLACE (State or foreign country) <u>MD</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Harold Henry Wagner</u>			14. MOTHER'S MAIDEN NAME <u>Eudora Gore</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>			16. SOCIAL SECURITY NO. <u>None</u>		
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA BILATERAL</u> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ABDOMINAL CARCINOMATOSIS</u> DUE TO (c) <u>CARCINOMA OF SIGMOID COLON RECURRENT</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>9 MONTHS</u> <u>13 MONTHS</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>March 7, 1959</u> to <u>July 24, 1959</u> , that I last saw the deceased alive on <u>July 24, 1959</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>George Beren, M.D.</u>			ADDRESS (Street, city or town, state) <u>Western Md. State Hospital</u> DATE SIGNED <u>July 24, 1959</u>		
PHYSICIAN'S NAME (Type) <u>DR. GEORGE BEREN</u>			Hagerstown, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baile's</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Carroll Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Luther H. Haight</u> ADDRESS <u>Hagerstown, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>JUL 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kiser</u>

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Md.		c. LENGTH OF STAY IN 1b 35 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fayette Middle Yunker Last Yunker		4. DATE OF DEATH Month 7 Day 5 Year 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5.22.1902
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 1 Days 13 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LaFayette Dick		14. MOTHER'S MAIDEN NAME Lydia L Shives	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ralph Yunker		Address 27 W. Main St. Hancock Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.0 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Arteriosclerotic heart disease (b) 10 yrs. (c) 5 years.			INTERVAL BETWEEN ONSET AND DEATH 2 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15 , 19 59 , to July 5 , 19 59 , that I last saw the deceased alive on July 2 , 19 59 , and that death occurred at 5:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank B Thomas III MD		ADDRESS (Street, city or town, state) 121 High St. Hancock, Maryland	
PHYSICIAN'S NAME (Type) Frank B. Thomas III, M.D.		DATE SIGNED July 8, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7.8.59	22c. NAME OF CEMETERY OR CREMATORY St Thomas	22d. LOCATION (City, town, or county) (State) Hancock Washington Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Givens		ADDRESS Hancock Md	
24a. REC'D BY REGISTRAR Andrew S. Hines		DATE JUL 10 1959	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAXYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

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For this use

Washington

Virginia

Maryland

West Virginia

Hagerstown, Maryland

Frederick, Maryland

Hagerstown, Maryland

27. Hagerstown, Maryland

Frederick, Maryland

Frederick, Maryland

Frederick, Maryland

V.A.A.

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